

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

SAGE SCHMIDT, A Minor,)
By and Through Doran)
Schmidt, her Natural Mother)
and Next Friend, and DORAN)
SCHMIDT, Individually,)
)
Plaintiffs,) 8:13CV143
)
vs.) Omaha, Nebraska
) July 28, 2015
THE BELLEVUE MEDICAL)
CENTER, LLC,)
)
Defendant.)

VOLUME II - TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE LAURIE SMITH CAMP
CHIEF UNITED STATES DISTRICT JUDGE

A-P-P-E-A-R-A-N-C-E-S

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Proceedings recorded by mechanical stenography, transcript
produced with computer.

1 (At 9:14 a.m. on July 28, 2015, with counsel for the
2 parties, plaintiff Doran Schmidt, and the defendant's
3 representative present, and the jury NOT present, the
4 following proceedings were had:)

5 THE COURT: Good morning.

6 MR. WELCH: Good morning, your Honor.

7 MR. PATRICK CULLAN: Good morning, your Honor.

8 THE COURT: I understand that there are some matters
9 that counsel would like to discuss before the jury comes in.

10 I'll start with the plaintiff. Any issues that the
11 plaintiff would like to discuss?

12 MR. PATRICK CULLAN: Yeah, just a couple procedural
13 ones.

14 At one point during the examination -- I don't know
15 when -- I would like the witness to be able to walk down and
16 use the actual fetal monitor tracing -- two of them actually.
17 One was marked up by the defendant nurses at their deposition
18 -- and describe and explain what it is.

19 And then the second one would be to just take a clean
20 monitor strip and explain the concepts that he will have
21 already described and its applicability to the strip.

22 And then the strip itself, your Honor, is about 12 hours
23 of recording. So it's -- I don't know the best way to do it,
24 I mean -- because he'll need to reference it here. Is it okay
25 that he comes here? Where would you want me to question him?

1 THE COURT: Well, let me explain a little bit about
2 the technology here.

3 MR. PATRICK CULLAN: Okay.

4 THE COURT: I understand that these exhibits you're
5 referring to, the fetal monitor strip exhibits, are, in fact,
6 paper exhibits; is that correct?

7 MR. PATRICK CULLAN: That's correct, your Honor.

8 THE COURT: Okay. So you can put those on that
9 overhead. And if they are received into evidence, they can be
10 shown to everyone, including the jury.

11 If they're not yet received into evidence, they could be
12 shown just to the witness and to me and to counsel. And
13 Ms. Frahm can assist with that technology. And the witness
14 sitting in the witness box can view the exhibit and can, in
15 fact, mark on the exhibit using his finger on the screen,
16 marking arrows, drawing lines.

17 And that is usually the preferable way to get that
18 evidence into the record and explain it to the jury without
19 the witness needing to leave the witness box. And that way he
20 is right next to the microphone, and it's less confusing.

21 So does that answer your question?

22 MR. PATRICK CULLAN: Yeah. That would -- maybe we
23 can play around with it so he knows how to use it.

24 THE COURT: Well, people usually play around with
25 that before trial.

1 MR. PATRICK CULLAN: Okay. I didn't know that --
2 okay.

3 THE COURT: And I know that you are a little bit
4 concerned about trying to get Dr. Gubernick's testimony
5 completed today. So you may want to go ahead and get him out,
6 especially since we have the long mid-day break today. I will
7 suggest that we just go until 11:30 without a 15-minute break.
8 That will help a little bit.

9 But it's up to you. It's your time, it's your witness.
10 If you wish to try to learn how the equipment works at this
11 time with your witness, we will sit and wait while you do
12 that.

13 MR. PATRICK CULLAN: Would you be okay if he does
14 it -- if he can -- would you be okay if he came down and just
15 drew on it? Or do you prefer the --

16 THE COURT: Well, he needs to be by a microphone
17 where everyone can hear him. And I won't tell you how to put
18 on your case. As long as the exhibit is in evidence, it can
19 be shown to the jury.

20 And if it's on that overhead projector, we can make sure
21 that the jury can see it on the monitors.

22 MR. PATRICK CULLAN: Okay.

23 THE COURT: Beyond that, it's up to you how you want
24 to present your case.

25 MR. PATRICK CULLAN: Okay. Thank you.

1 We'll try it with the technology when he's seated. Do
2 you want to try it now?

3 THE WITNESS: I'd be happy to.

4 THE COURT: Okay. We'll just go off the record now.

5 (Off-the-record discussion had.)

6 MR. PATRICK CULLAN: There's one other issue.

7 THE COURT: Let's go back on the record then. We're
8 on the record again.

9 MR. PATRICK CULLAN: There was another issue that
10 came up last night with defense counsel.

11 During discovery, they produced policies and procedures.
12 They're not on the exhibit list but they are the hospital's
13 policies and procedures. Defense counsel suggested last night
14 that we can't make a reference to them because they weren't on
15 the exhibit list.

16 My understanding is that that's not true, we can make
17 reference to them, we can discuss what they state. Putting
18 them in evidence is different because they're not on the
19 exhibit list.

20 I would represent to the Court it is what it is. It's
21 the hospital's policies.

22 THE COURT: And again, I can't rule until there is a
23 motion or an objection.

24 If there is a witness on the stand who has knowledge of a
25 certain practice, procedure, regulation, that witness may be

1 qualified to testify on that subject.

2 Certainly witnesses cannot read from documents that are
3 not in evidence.

4 That may not answer your question. But until there is an
5 objection, I have nothing to rule on.

6 MR. PATRICK CULLAN: Okay.

7 MR. WELCH: Just to pick up on that, your Honor,
8 counsel's correct, the policies and procedures, one, have not
9 been listed as an exhibit in this case. That's number one.

10 Number two, with this witness, if the issue of Bellevue
11 Medical Center's protocols and procedures come up, it's a
12 violation of Rule 26 because nowhere in this witness's report
13 does he ever list that he has reviewed those policies and
14 procedures. That's number one.

15 And nowhere in his 20 -- or 267-page deposition does he
16 ever refer once to the policies or procedures. And I
17 specifically asked him for all of his opinions with respect to
18 Bellevue Medical Center and the basis for those opinions. And
19 those policies and procedures are never mentioned.

20 So this is unfair surprise if counsel is going to either
21 just simply, through testimony, elicit whether the nurses met
22 or complied with our own policies.

23 So it goes much deeper than just not listing it on the
24 exhibit list. And I think it's improper. It violates Rule
25 26. He had to disclose all of his opinions and the basis for

1 those opinions, and he didn't.

2 So you're right, we're not there yet. But I wanted to
3 bring it to your attention that we have a strenuous objection
4 to him being able to discuss any of that at all because it's
5 never been disclosed before, that that's one of his opinions.

6 I don't mean to cut you off. Do you have any other
7 issues? Because I've got two more.

8 MR. PATRICK CULLAN: Go ahead.

9 MR. WELCH: Okay.

10 THE COURT: And I will just note that if an expert
11 begins to offer testimony that is outside the scope of the
12 expert's report, and there's an objection, we'll probably have
13 a sidebar, I will look at the report; and unless counsel who
14 is engaged in the examination of the witness can point out in
15 the report where this opinion is disclosed and the basis for
16 the opinion is disclosed, I'll sustain the objection.

17 So that may help you -- give you a heads-up and help
18 avoid some sidebar conversations.

19 MR. PATRICK CULLAN: Thank you, your Honor.

20 THE COURT: Mr. Welch?

21 MR. WELCH: Your Honor, I want to go back to an issue
22 that we talked about yesterday. It's the *Jensen vs. Bergan*
23 case. You brought up an issue with respect to mid-level
24 provider, nurse-midwife as opposed to physician.

25 I expect that there will be objections today as to the

1 nurses, their ability -- whether they should diagnose and
2 whether they have to follow specific orders.

3 I placed a phone call to my office yesterday, had some
4 quick research done. I apologize to counsel, I only have one
5 copy. And I would like to provide to the Court -- this is
6 from the Nebraska Health and Services -- Human Services
7 regulation and licensure.

8 It talks about a certified midwife and that they have a
9 -- have to have a corroboration agreement with a physician.
10 And specifically in the practice agreement, they provide, in
11 paragraph 104-005.01, that they have a practice agreement and
12 they outline their scope of practice, one of which is
13 attending cases of normal childbirth, providing prenatal
14 intrapartum and postpartum care, providing normal obstetrical
15 and gynecological services for women, providing care for the
16 newborn immediately following birth, and prescribing legend
17 drugs, Schedule II controlled substances, for up to 72 hours
18 for pain control and Schedule III, IV, and V controlled
19 substances.

20 There's also another section that I will provide to the
21 Court -- and I've tabbed both of these -- for APRNs, advance
22 practice registered nurses, of which Nurse Ramsey is also.
23 And it also provides for an integrated practice agreement
24 where they have to have a corroborating physician and -- when
25 they practice.

1 So I guess my point is, your Honor, I understand the
2 distinction. But I think, given the circumstances how this
3 woman was practicing as it relates to vis-à-vis the nurses,
4 they have an obligation to follow that provider's orders.

5 And the fact that that provider is supervised by a
6 physician, has a corroborating agreement with that physician
7 by the regs, and that she has privileges at the hospital to
8 prescribe medication -- narcotic medication, and to provide
9 delivery services, it's a distinction, but I don't think it's
10 a difference. The nurses still have an obligation to follow
11 the instructions of that provider.

12 THE COURT: So what you're offering to show me is
13 part of the Nebraska Administrative Code; is that correct?

14 MR. WELCH: Yes, your Honor.

15 THE COURT: Okay. Well, I believe I can take
16 judicial notice of the Nebraska Administrative Code. And
17 counsel should be able to access the Nebraska Administrative
18 Code if you provide him with the citation to it.

19 MR. WELCH: I will.

20 THE COURT: And ultimately, this may be something
21 that we need to address at the jury instruction conference to
22 instruct the jury about the responsibility of the nurses to
23 either follow the orders of the certified midwife or not.

24 But I'm not prepared to rule on that at this time. I
25 guess that's as much as I can say at this juncture.

1 I appreciate you providing me with that information. I
2 realize that there are many different classifications of
3 medical professionals now, including nurse practitioners,
4 including physician assistants. And they have different
5 levels of expertise and authority.

6 But I'm not an expert or someone well versed on the
7 various distinctions and who is obligated to follow the orders
8 of whom, other than what you've pointed out to me in the
9 Nebraska Supreme Court cases regarding physicians and nurses.

10 MR. WELCH: Okay. And just so I don't get crosswise
11 with the Court, when that -- if that issue comes up with this
12 witness, in order to preserve my record, I will be making
13 objections, citing the *Jensen vs. Bergan* case to the Court,
14 and that that testimony would be a violation of Nebraska law.

15 So that's why I brought it up to the Court now. I don't
16 want to, you know -- I didn't want to blindside you on my
17 objections and the basis for my objections. And I understand
18 your ruling.

19 THE COURT: Well, and I can tell you and counsel for
20 the plaintiff that if any witness begins to offer testimony as
21 an expert on the law, that line of questioning will be
22 objectionable, and I will sustain objections to that.

23 So if any witness indicates that a nurse is not obligated
24 to follow the instructions of a nurse-midwife, that may be a
25 question of law. And it's my job to instruct the jury on what

1 the law is, and I will advise the jury of that.

2 All right. Anything else?

3 MR. WELCH: One more.

4 THE COURT: Okay.

5 MR. WELCH: Plaintiff's counsel -- I don't know if
6 he's going to with this witness, he has in the past used a
7 Pitocin package insert.

8 It's never been listed as an exhibit. So if he wants to
9 refer to it, I will have objections on that because I believe
10 it's outside the scope of what the witness has previously
11 testified to or at least within his report.

12 But I don't want any publishing to the jury of a package
13 insert on Pitocin. That's all I have.

14 THE COURT: All right. Any documents that have not
15 been received into evidence may not be published to the jury.

16 MR. PATRICK CULLAN: Just -- my intention with
17 that -- and I do believe it is on the exhibit list -- my
18 intention was just as a learned treatise hearsay exception.
19 He can read from it but it cannot be presented to the jury.

20 THE COURT: Well, if it's something that he relied on
21 in reaching his opinion and that was fairly disclosed, then he
22 may testify accordingly.

23 Anything further before the jury comes in?

24 MR. WELCH: No, your Honor.

25 THE COURT: Mr. Cullan?

1 MR. PATRICK CULLAN: No, your Honor -- oh, I think
2 I --

3 THE COURT: Very good. Please bring in the jury.
4 (Jury in at 9:31 a.m.)

5 THE COURT: Please be seated. Good morning.

6 Thank you very much for your patience. The lawyers and I
7 have been going through some procedural matters here while you
8 were waiting. And I hope that what we were accomplishing
9 during that half an hour will actually end up saving you time.

10 I will mention that our schedule today is a little bit
11 different from our standard day. You will have a long noon
12 break today. I hope that the weather clears up so that if you
13 want to take a stroll and explore the culinary opportunities
14 in a wider radius around the courthouse, you can do that.

15 But just so you're aware of the schedule, we will be in
16 court until 11:30. So we won't take another break since this
17 will simply be a two-hour period of time. And we will break
18 at 11:30. And then we will reconvene at 2 and go until five
19 o'clock.

20 At this time, the plaintiff may call her next witness.

21 MR. PATRICK CULLAN: Your Honor, at this time we
22 would call Dr. Martin Gubernick.

23 THE COURT: Dr. Gubernick, if you'll please come
24 forward to the courtroom deputy here -- you're fine. The
25 courtroom deputy will swear you in right over here.

1 Thank you.

2 COURTROOM DEPUTY: State your full name for the
3 record, please, and spell your last name.

4 THE WITNESS: Martin Gubernick, G-u-b-e-r-n-i-c-k.

5 MARTIN GUBERNICK, PLAINTIFFS' WITNESS, SWORN

6 THE COURT: You may inquire.

7 MR. PATRICK CULLAN: Thank you, your Honor.

8 DIRECT EXAMINATION

9 BY MR. PATRICK CULLAN:

10 Q. Doctor, could you state your name and spell your name --
11 last name for the record?

12 A. Martin Gubernick, G-u-b-e-r-n-i-c-k.

13 Q. What is your occupation?

14 A. I'm an obstetrician/gynecologist.

15 Q. What is an obstetrician/gynecologist?

16 A. I take care of women. And half of my professional life,
17 I take care of pregnant women.

18 And taking care of pregnant women means taking care of
19 them during their pregnancy, while they're in labor, and then
20 in what we call their postpartum period after they deliver.

21 Q. Okay. So there's an obstetrician part and a gynecologist
22 part.

23 A. And there's a Gyn part where we take care of women's
24 needs throughout their life, Pap smears when they're younger,
25 and then various issues that come up later in life, the

1 importance of mammography, screening for various cancers.

2 I'm also a gynecologic surgeon, so I do laparoscopic
3 procedures, minor procedures like D&Cs, major procedures like
4 hysterectomies, things of that nature.

5 Q. Have you come here to Omaha today to render opinions to
6 the jury about whether or not the Bellevue Medical Center, by
7 and through its nurses, violated safety principles in the care
8 and treatment of Doran Schmidt and her baby, Sage?

9 A. Yes.

10 MR. WELCH: Objection, form of the question, your
11 Honor; violates the Court's motion in limine.

12 THE COURT: Overruled.

13 A. Yes. That's why I'm here.

14 BY MR. PATRICK CULLAN:

15 Q. And before we get to the opinions, I need to lay some
16 foundation. So tell me -- walk us through your educational
17 experience. Is that --

18 A. Sure. So I grew up in New York City, went to public
19 school there. Then in 1974, I went to Bucknell University in
20 Lewisburg, Pennsylvania. I received a degree of bachelor of
21 science in biology. I graduated Phi Beta Kappa, highest in my
22 class in grades. And then I graduated in 1978.

23 And then in 1978, I went to Northwestern University.
24 That's in downtown Chicago. And that was a four-year program
25 -- medical school is a four-year program. I attended medical

1 school from 1978 until 1982. I graduated in 1982 with an MD
2 degree.

3 And from there, I went to the New York Hospital. That's
4 part of Cornell University. Now it's part of both Cornell
5 University and Columbia. Those two Ivy League schools have
6 merged together under one umbrella. When I was there, it was
7 just part of Cornell. I did a four-year residency, completed
8 that residency in 1986.

9 I became a clinical instructor at the medical school.
10 And then I went into private practice, what we call voluntary
11 -- part of the voluntary staff of the New York Hospital. So I
12 have a nonpaid position at the hospital as a clinical
13 instructor. Not a professor, I don't do classroom -- what we
14 call didactic teaching. I'm not one of those people that go
15 in and write on the blackboard and give exams.

16 I teach the clinical aspect of being an
17 obstetrician/gynecologist. So I teach to nurses, nursing
18 students, medical students, residents, on occasion fellows and
19 other attendings.

20 I also have a private practice outside of the hospital,
21 which is about seven or eight blocks from the hospital. And
22 I've done this since 1986. So I continue to be a clinical
23 instructor. I'm board certified in ObGyn. And I have a
24 private practice both in obstetrics and gynecology.

25 Q. You mentioned a couple things here and I just want to

1 talk about those.

2 One thing you just mentioned was you're board certified.

3 Tell us about what that is and what the significance is.

4 A. Sure. There's an entity called the American Board of
5 ObGyn. And they're a licensing -- they're an accreditation
6 board. In order to call yourself board certified, you begin
7 with a two-step process.

8 You're eligible to take a written exam upon completion of
9 your residency program. And if and when you pass that exam,
10 you then collect all your cases for a year, all your
11 obstetrical cases and all your Gyn cases, everybody you've
12 operated on, everybody you've delivered. You collect those
13 cases. You submit it to the board.

14 And examiners of the boards are usually people like
15 chairmen of the departments throughout the country. And you
16 submit it and -- well, when I was taking my oral boards, it
17 was in Chicago -- coincidentally where I went to medical
18 school. And you sit in a hotel room with three examiners.
19 And they ask you all kinds of questions about your list, why
20 you -- how you managed this labor patient, why you operated on
21 that patient, what were you thinking, what were you -- what
22 were the options. And then when they're done with their list,
23 they ask you whatever questions they want to ask you in
24 general.

25 So I passed my boards in 1987, the earliest time I could

1 have done because I took my written exam in '86; passed it,
2 submitted a year's worth of data to them in '87, took my oral
3 exams in '87.

4 And then in the '80s and '90s, recertification required
5 you take a written exam every ten years to get recertified.
6 So I took a written exam in 1997. I was -- passed that. I
7 was due to take an exam in 2007. And then approximately 2002,
8 2003, the board said rather than take an exam every ten years,
9 we'd rather have -- we're going to give you an option that
10 we'll send you 50 articles a year, and you're going to take a
11 test on those 50 articles. And if you pass -- if you read
12 those articles, then you're board certified. So starting
13 2003, 2004, somewhere around there, I started to do that.

14 And as of recently -- now they've even said -- they've
15 gotten a little tougher -- they say, not only do you have to
16 take the -- read those papers, but every six years, you have
17 to then take your written exam over again, instead of every
18 ten years because you've been doing the articles.

19 So in 2014, I took my written exam, passed that, and I'm
20 current. And I did my papers this year already in 2015.

21 Q. Okay. Now just walk us through globally by your career
22 as a physician, in any capacity, whether residency, so forth,
23 how many deliveries have you participated in?

24 A. So I've done thousands of deliveries; probably my
25 residency, I don't know, maybe 500 to a thousand. For the

1 majority of my professional career, I've done about 100
2 deliveries a year, 100 to 120 a year.

3 The last five to seven years, what happens naturally in
4 the field of obstetrics and gynecology, as the doctor gets a
5 little older, the patients who follow you through time get a
6 little older. So my Gyn practice has gotten a little busier.
7 My OB practice has gotten a little bit lighter.

8 Now I'm doing about 60, 75 deliveries a year. I'd say
9 that's been going on for five, seven years or so. My Gyn
10 service has probably gotten a little bit busier. That's the
11 natural course of what happens to us.

12 Q. Okay. How many -- that was labors.

13 Let's talk about pregnancies itself. How many
14 pregnancies have you followed and managed, again encompassing
15 your entire career?

16 A. Thousands. You know, because -- well, I went into
17 practice in 1986. I can't believe it, but it's going to be 30
18 years next year.

19 So if I've averaged somewhere around 90 to 100 deliveries
20 for most of my career, that puts me at about 2500 to 3,000
21 deliveries, excluding the amount I did in my residency.

22 New York Hospital is an extremely busy institution. We
23 do 6,000 deliveries a year. As a resident, you do lots and
24 lots of deliveries. So I've done my share of deliveries.

25 Q. Okay. I guess we talked about pregnancies, labors --

1 A. Yeah.

2 Q. -- and deliveries, you mentioned.

3 And I guess if you could break us down, percentage that
4 you would have a patient deliver vaginally versus operative,
5 vaginal versus caesarian sections, explain the difference of
6 those and explain what your experience is with each one of
7 those.

8 A. Sure. Well, there are three ways -- we sort of break it
9 down. There's caesarian section, there's vaginal deliveries,
10 and there's operative vaginal deliveries.

11 Operative vaginal deliveries is using forceps and
12 vacuums. Up until the mid '90s, they were very popular tools
13 in facilitating deliveries. They've become much less popular
14 in the last five or ten years. Throughout the entire United
15 States, there's much less use of vacuums and forceps, although
16 I did a lot of that -- a lot of forcep. We weren't big on
17 vacuums. I did a lot of forcep deliveries in my career in the
18 '80s and '90s. I would say that's a fairly infrequent event
19 now that -- forceps are almost unheard of. We're not training
20 our residents to learn how to use forceps. So it's unusual to
21 see a young ObGyn who even knows how to put a forcep on.

22 We're one of the most prestigious institutions in the
23 United States. And I can tell you residents coming out of our
24 program really don't -- they don't know how to use forceps.
25 But they do know how to use the vacuum. It's easier to put

1 on. Put it on the baby's head and pull. So I would say 10
2 percent of the deliveries are vacuum deliveries.

3 As far as vaginal deliveries, caesarian section, I have a
4 low caesarian section rate compared to the U.S. statistics,
5 mostly because I have a fairly healthy population. I take
6 care of generally healthy people.

7 I don't hold it against people with a high caesarian
8 section rate because if you have a complicated patient base,
9 if you're a maternal-fetal medicine expert, you have a lot of
10 high-risk obstetrics, you may have a 30, 40 percent section
11 rate. I have about a 20 percent section rate. The national
12 statistic is somewhere around 28 to 30 percent right now.

13 So I would say roughly one out of five or so of patients
14 that I take care of the pregnancy end up with a caesarian
15 section.

16 Q. Okay. One concept we might hear about at some point
17 during this trial is what's the difference between an
18 obstetrician and a family practice physician who engages in
19 obstetrics?

20 A. Well, there are different kinds of people who deliver
21 babies. And family practitioners are one kind. For un- --
22 they have -- they do a four-year residency, some of them have
23 three years, some of them have four years in family medicine.
24 And they probably spend about four to six months doing
25 obstetrics.

1 In my training, I did four years of obstetrics. And
2 every day of the week what I do is obstetrics. A family
3 practitioner, they may be taking care of diabetes, they may be
4 taking care of hypertension, they may be taking care of -- you
5 know, all kinds of different things, and they may do a
6 delivery now and then.

7 So for an uncomplicated delivery, a routine delivery, I'm
8 sure they do a fine job. When it comes to issues in
9 pregnancy, they do not have the same expertise as somebody --
10 as I do, nor do I have the expertise of taking care of
11 diabetes in a 60-year-old man. It's not that they have a
12 shortcoming, it's just that they haven't been trained to do
13 the things that I've been trained to do. And similarly, I
14 haven't been trained to do some of the things that they can
15 do.

16 Q. Okay. What hospital do you currently practice in?

17 A. So the name of my hospital -- I've been at that hospital
18 since 1982 when I started my residency. It was the New York
19 Hospital. Now it's called the New York Presbyterian Hospital
20 because, as I told you a few minutes ago, Columbia University
21 and Cornell University have merged. They've merged fiscally.
22 They're all under a single umbrella.

23 So we call our hospital -- because it's Columbia
24 Presbyterian, we call our hospital, for political correctness,
25 the New York Presbyterian Hospital.

1 Q. Okay. Now I want to talk about your experience with
2 working with nurses who are engaged as healthcare
3 professionals in labor and delivery.

4 A. So I couldn't do my job without the nurses. Nurses are
5 an integral part of what we do on labor and delivery. We're a
6 team. It's part of a team. And they're no more -- in the old
7 days, there were bosses on the team. Doctor was the boss; the
8 nurse, you know, different commands -- different levels,
9 captains, lieutenants.

10 Now we're a team. And I'm not -- as a matter of fact,
11 there are charge nurses on the floor, there are floor nurses
12 on the floor. I'm the obstetrician. I have a boss, too.
13 There's a head of OB; and he has a boss, the chairman of the
14 department. And he has a boss, the head of the hospital.

15 So what we have is we have a team approach, including
16 nurses, where we all have a common goal. And our common goal
17 is to be an advocate in obstetrics for two people, for the
18 mother and for the baby. So we all have the same goal. Send
19 those two people home healthy and happy.

20 Q. Okay. I want to talk about a couple concepts you
21 introduced in that answer.

22 The most recent you talked about, there's two patients.
23 Talk about how that's unique to the role you play as an
24 obstetrician versus other healthcare providers --

25 A. It's the only specialty that works that way. Most of the

1 time, the majority of the time, the concept is relatively easy
2 because the needs of the mom and the needs of the baby
3 converge. In other words, they have the same needs. And
4 what's in the mom's best interests is in the baby's best
5 interests.

6 But that's not always so. Many times -- it's not always
7 -- sometimes what's in the best interests of the baby is not
8 necessarily what's in the best interests of the mom.

9 And we have to have a dialogue about that. And moms have
10 to be aware of that, that there are things sometimes we have
11 to do that the mom may not necessarily -- in the ideal world,
12 if it was just her, she wouldn't necessarily want done. But
13 in the best interests of the baby, we do that. You know,
14 we -- we have to go to a plan B.

15 And vaginal delivery versus caesarian section is a
16 classic example. As a general principle, vaginal deliveries
17 are better for mom. It's not an operative procedure. They
18 heal quicker, faster recovery, something they like.

19 As a general principle, a general principle, caesarian
20 sections are safer for babies. They don't go through the
21 trauma of the birth process.

22 Most of the time, they have a converging interest; in
23 other words, the baby does just fine having a vaginal
24 delivery, the mom does just fine. But it's not always so.
25 And we have to sometimes make decisions to say in the best

1 interests of the baby -- sometimes it's in the best interests
2 of the mom to have a caesarian section. So sometimes we do
3 caesarian sections for the mom. But many times the indication
4 for the caesarian section is something we're doing for the
5 best interests of the baby.

6 Q. So I guess we can start talking a little bit about the
7 principles and the terms that we may be using throughout the
8 trial and your testimony here today.

9 I guess this may be obvious, but I know there's a
10 definition. What is labor?

11 A. So it's not so obvious. It's a good question.

12 Labor are uterine contractions -- let's start off by
13 saying that the baby grows inside of a muscle. And that
14 muscle is called the uterus. And the uterus is a contractile
15 organ. And it's designed, you know, like a tube of
16 toothpaste, to squeeze out the contents, to squeeze out the
17 baby. And the way it does that, it's like any other muscle in
18 our body, it contracts when it's time.

19 Now, sometimes it contracts, but they're not real strong
20 and they don't really do anything. We call those Braxton
21 Hicks contractions during pregnancy. And they just sort of --
22 you know, the uterus is testing itself out for what's to come.

23 But what is labor? Labor is regular uterine contractions
24 that lead to changes to the cervix, cervical dilatation and a
25 thinning of the cervix, what we call effacement.

1 So when the uterus contracts, and as a result of those
2 contractions, the cervix dilates and is effaced, that, by
3 definition, is labor.

4 Q. Okay. Two concepts you introduced again there. What is
5 dilation and what is effacement?

6 A. So the outlet of the uterus is called the cervix. The
7 cervix sits in the top wall of the vagina. It looks like a
8 doughnut -- a doughnut with a little -- like a hole in the
9 middle.

10 What has to happen is the lower uterine segment needs to
11 expand to let the baby in. And that doughnut needs to open
12 up. And we call that opening of the cervix dilation.

13 And just like a doughnut that's kind of thick, we need to
14 get paper thin. So not only is the cervix open, but as it
15 opens, it thins out. It gets like paper. It's what we call a
16 hundred percent effaced. And it completely thins out.

17 So what we want to do is flatten out the cervix like a
18 pancake and open up the middle. So that's dilation and
19 effacement.

20 Q. Okay. And how do you check and see what the dilatation
21 is and what the effacement is, how is that done?

22 A. You do that with a vaginal exam. When you've done enough
23 vaginal exams -- we use two fingers. And I know if I can open
24 my two fingers this far (indicating), the patient is 5
25 centimeters dilated. And if I open up this far, she's 7. And

1 then the goal is to get to complete dilation. That's 10
2 centimeters.

3 And just to keep it in perspective, there's 2.54, two and
4 a half centimeters to an inch. So the cervix has to open
5 about four inches in order to let the baby through.

6 Q. Okay. Are there -- so labor, we know you gave us a broad
7 definition of that. Is it broken down in any way?

8 A. Yes. So what we do as obstetricians, we study labor. We
9 want to know when labor is normal; and for the health and
10 well-being of both mother and baby, we want to know when labor
11 is abnormal.

12 So the advantage we have in obstetrics, we have millions
13 and millions of people who go into labor all the time. And we
14 can study these people and we study the timeline. And we know
15 by looking -- and there are champions in the field who have
16 looked at that. The gold standard is a man called Emanuel
17 Friedman, who actually did that at Colombia University in New
18 York. And almost every obstetrical chart in the United States
19 has, in the chart, what's called the Friedman Curve.

20 And what it shows is over time, what happens to the
21 cervix in terms of how it dilates, what happens to the cervix
22 as it effaces, and how the baby moves into the birth canal and
23 comes out. So we call that change in station, the movement of
24 the baby down and out.

25 So we've looked at -- not we because I didn't do those

1 studies, I don't want to pretend like I did -- but people like
2 Emanuel Friedman, he looked at these women, and he measured it
3 over time, how long it takes the average woman who is having
4 the first baby to dilate from 1 centimeter to 3 to 4 to 5; how
5 long it takes for somebody that's got three or four babies,
6 because depending on the number of babies you have, will
7 determine the speed of how fast the baby comes out.

8 So he broke down labor into stages. And the first stage
9 of labor is the start, the cervical dilatation, what we talked
10 about before, contractions leading to cervical dilatation and
11 effacement. That's the start of the first stage. And the
12 first stage ends when the woman is fully dilated.

13 And that stage is broken down into a latent phase that
14 moves slowly -- because the first couple of centimeters don't
15 go so fast -- and then the active phase that's much faster.
16 And we know during the labor phase how long it should take,
17 during the active phase. And we know for primips, first-time
18 mothers, and for multi, second-time mothers.

19 And then there's the second stage of labor. That's when
20 the mom starts to push. And that ends when the baby comes
21 out.

22 And the third stage of labor is when we deliver the
23 placenta.

24 Q. Okay. So those are the stages. Are there -- I guess
25 that's normal labor.

1 A. So normal labor, when we talk about normal labor, what
2 are we talking about? We're talking about a baby who is
3 moving at the right speed and a cervix that's dilating in the
4 proper time frame and effacing in a proper time frame.

5 And we have this curve, this graph that we look at. And
6 we know that in the early parts of labor, if you see the
7 graph, you know, if it's a -- if the bottom line is time, and
8 the -- you know, the vertical is dilation, it's kind of a flat
9 line. It moves kind of slowly until the woman gets to be 4 or
10 5 centimeters dilated. And then the curve starts to go like
11 this (indicating) because the cervix starts to change quickly
12 over a short period of time. So the curve sort of looks like
13 a hockey stick. You know, the bottom, it's kind of flat; and
14 then, boom, it takes off.

15 Q. Okay. Is it a fair assessment that the further one is
16 into the labor process, the faster the labor should go?

17 A. Yes. Once we're in the active phase of labor -- and in
18 all fairness, since Emanuel Friedman did his work in the late
19 '60s, early '70s, other authors like Zang came ahead and said
20 -- because Friedman said you should expect things to start
21 happening quickly when the cervix is 4 centimeters.

22 Well, now there's some talk that maybe we should wait
23 until it's, you know, really call it 5 or even 6 centimeters.
24 So there's a little debate what the -- when the active phase
25 of labor really starts.

1 I'll tell you most obstetricians in the United States
2 follow the Friedman philosophy of it being about 4
3 centimeters. But very reasonable people will talk about maybe
4 starting at 5 or 6 centimeters.

5 Q. Okay. That's an academic difference. Does that have --

6 A. And that's an academic --

7 THE COURT: As you know, we can only have person
8 talking at a time.

9 We'll go ahead with the question, Mr. Cullan.

10 BY MR. PATRICK CULLAN:

11 Q. Does that academic difference have any applicability to
12 this case?

13 A. Nothing whatsoever.

14 Q. Okay. Because it's -- when things went wrong here, we're
15 at 7 centimeters.

16 A. We were 7 centimeters. We were --

17 MR. WELCH: I'm going to interpose an objection to
18 the form of the question.

19 THE COURT: All right. Sustained.

20 MR. WELCH: And ask that the jury be instructed to
21 disregard.

22 THE COURT: The jury will disregard that last
23 response.

24 Go ahead, Mr. Cullan.

25 MR. PATRICK CULLAN: Okay.

1 BY MR. PATRICK CULLAN:

2 Q. So let's look at those principles and -- so what is -- we
3 talked about a normal labor. What is abnormal labor?

4 A. So when things don't go well, right -- now we're not
5 talking about, like, emergencies, like a placenta separating,
6 abruption. There's all kinds of things that can happen. But
7 let's focus in on the labor curve, what's abnormal. That's
8 what we're going to be talking about today.

9 And abnormal means something's either occurring too
10 slowly or it's actually stopped. And when it's occurring too
11 slowly, we call it a protraction phase. It is -- it's moving
12 too slow. And when it stops, we call it an arrest. What
13 we're going to be talking about here today is an arrest of the
14 active phase of labor.

15 Q. Are there recognized time limits for -- are these terms
16 defined, I guess?

17 A. Yes.

18 Q. And so what would be a protraction -- okay. Are the
19 times broken up between first-time moms and women who have had
20 more than one pregnancy?

21 A. Yes. So remember what I said before -- and we all know
22 this. When you've had a lot of kids, babies come out quickly,
23 okay? And when it's your first time, it happens slower. It
24 happens, but it happens slower. And we all know that.

25 And I will tell you, in the active phase of labor, we

1 expect the cervix, for a first-time mother, to dilate 1.2
2 centimeters an hour. And that's by looking -- where do we
3 come up with that number? That's by looking at thousands and
4 thousands of deliveries, maybe millions of deliveries, and
5 plotting it out over time. And from the start of the active
6 phase of labor to full dilatation, we expect that to be 1.2
7 centimeters.

8 A multip, one or more children, it's 1.4 to 1.5
9 centimeters an hour. They're faster. Okay?

10 And so when it gets stuck and the cervix just doesn't
11 move anymore, we call that an arrest. And when it gets stuck
12 for any -- and again, reasonable people, Emanuel Friedman, the
13 godfather, says when it gets stuck for two hours, that's an
14 arrest. Some reasonable people have challenged him and said,
15 well, maybe it should be four hours and not two hours, we
16 should give people a little more time.

17 So somewhere with good uterine contractions, the uterus
18 contracting really nicely, if you're -- if you believe in the
19 school of Emanuel Friedman, you say if someone is stuck for
20 two hours, that is an arrest. If you're in the more -- a
21 newer school and you want to give people more time, you can
22 say no, I think it should be four hours.

23 Anything slower than that 1.2 or 1.4, depending on
24 whether it's a first baby or not, if you have more than one
25 baby, we call that protraction of labor. Hasn't arrested, but

1 it's not moving at a great pace.

2 Q. Okay. So talk to us now -- this is kind of in line but
3 we're going to introduce a concept. What is a differential
4 diagnosis?

5 A. So a differential diagnosis is when something is going
6 on, you have an -- something has happened, you want to have an
7 idea why has that happened? And that's what a differential
8 diagnosis is.

9 In other words -- let's cut to the chase here. If, all
10 of a sudden, the baby gets stuck, you want to know why is the
11 baby stuck. Because in the differential diagnosis, there is
12 more than one possibility.

13 Should I talk about those possibilities?

14 Q. That was my next question. What are the various
15 possibilities applicable to the situation?

16 A. So here's what we teach every medical student in the
17 country who's doing obstetrics and gynecology. When a baby
18 gets stuck, you've got to think Ps.

19 What is Ps? You've got to think of the passage. You've
20 got to evaluate the size of the mom's pelvis because maybe the
21 pelvis is small and things get stuck because the person has a
22 small pelvis.

23 Then there's the passenger, and that's the baby. And
24 maybe the baby is too big. It's just that simple. Maybe the
25 baby is too big, and the baby can't fit through the pelvis.

1 Then there's position, because a certain size baby may be
2 able to fit through if it gets into a nice flexed position
3 with its chin to its chest, you know, think about -- think
4 about when you're jumping into a swimming pool. If you're
5 jumping in head first, you don't need a lot of room in front
6 of you in the water.

7 But imagine you're doing a back flip. And you want to go
8 -- come back this way (indicating). You need a lot more room
9 in the pool or you're going to hit your head on the side of
10 the pool.

11 So depending on the position of the baby, whether the
12 baby has its head flexed or extended, or whether it's looking
13 to the side or it's looking up at the sky or it's looking down
14 at the floor, the position can have an effect on whether
15 things -- why something has gotten stuck.

16 Then there are the powers. What do we mean by "powers"?
17 The force of the uterine contractions. Because in some cases,
18 the mother's contractions are not strong enough. So we have
19 to evaluate that because we have a drug that can increase the
20 force of the contraction.

21 But before increasing the force of the contraction, we
22 have to go through a differential diagnosis because if baby's
23 too big, if the pelvis is too small, if the position is not
24 right, and the powers are just fine, the very last thing you
25 want to do is increase the powers. That's not a good idea.

1 It's like, you know, if the desk isn't fitting through
2 the doorjamb, and you try to change the angle, you've
3 evaluated the size of the doorjamb, you've evaluated the size
4 of the desk, the answer to get the desk through the doorjamb
5 is not to push harder through the doorjamb. You're going to
6 hurt the jamb, you're going to hurt the desk.

7 So you've got to make sure before you mess with the
8 powers that the powers are the problem.

9 Q. Okay. So you talked about a couple things there. What
10 are the risk factors when you take a woman -- to give you an
11 idea if there could be a potential problem with the first P,
12 the pelvis?

13 A. So the first thing we do is we examine patients. We
14 examine patients early in pregnancy to try to get a feel of
15 their pelvis. I'll tell you, that's the hardest thing. Of
16 all those things we talked about, that's the hardest thing to
17 do, to do a vaginal exam and get an idea that -- you know,
18 there are different shapes, four basic shapes that women's
19 pelvises can have. And the best of obstetricians have trouble
20 with that. I'm not saying we can't do it, but it's a hard
21 thing to do. We try. We've looked into doing things called
22 allometry, where you actually take pictures with X-rays and
23 MRIs and CAT scans to see if we can -- that doesn't work well.

24 So anyway, we do our best. It's a clinical assessment.
25 We do it with the pelvic exam to try to assess the size of the

1 pelvis.

2 Q. Okay. And how about -- let's go to position. Talk about
3 what are the various positions, which are optimal, and which
4 are more likely to cause a problem.

5 A. When do we start thinking about positions? Somebody
6 approaches term and are ready to deliver. And what we want to
7 know is where is this baby in the pelvis? And I'll tell
8 you -- remember we talked about station, where the baby is in
9 terms of the pelvic outlet?

10 Now, most, 80 plus, maybe 90 percent, of women just
11 prior -- before they go into labor, their baby engages. It's
12 what we call zero station. Zero is the engagement. It's when
13 the biparietal diameters -- and this is the parietal bones of
14 the head -- is at the level of the woman's spines in her
15 pelvis.

16 And most women are engaged. When you're not engaged, as
17 an example in this case, at 39 weeks, it's not a red flag. It
18 doesn't mean the baby is not going to fit. But it's a yellow
19 flag. It's like, why is this baby high? And you start
20 thinking. Is it a position? Is the baby looking to the left?
21 Is the baby looking to the right? Is the baby looking up to
22 the sky?

23 We want the baby -- like that diver going into the pool,
24 the optimal position is the baby's back to the mother's back,
25 the chin tucked in, and the baby looking down at the floor.

1 That needs the least amount of room to get through the pelvis.
2 That's the most optimal position.

3 So if the baby is sitting here -- we know in this case,
4 before she went into labor, the baby was at a minus three
5 station. It was an unengaged station. It's a yellow flag
6 that why is this baby, before labor, not getting into the
7 right zone?

8 Q. Okay. You mentioned the position, but what is OA or
9 occiput anterior, and how does that differ from --

10 A. Okay. So --

11 THE COURT: Wait, wait. I'm going to interrupt you
12 again because we still have an overlap between the questions
13 and the answers.

14 THE WITNESS: I apologize.

15 THE COURT: I'm going to ask Dr. Gubernick to wait
16 for a beat after the question before you start the answer.

17 Go ahead. Thank you.

18 THE WITNESS: My apologies.

19 A. So we have jargon. And we decide that when we talk about
20 positions based on the occiput, the top of the head, what we
21 call OA means the occiput is anterior. It's up towards the
22 mother's belly button. So the baby is looking down at the
23 floor.

24 OP, it's posterior. The baby is looking up at the sky.
25 And then there's all sorts of variations. ROA, to the

1 mother's right, still looking to the floor; LOA to the left.
2 Then we have transverse.

3 It's just jargon. Basically if you just think about the
4 baby, it would be like a clock. Either it's looking at six
5 o'clock or it's looking at nine o'clock or it's up looking at
6 12 o'clock or three o'clock. And those are the various
7 positions.

8 Q. Okay. Which of those -- I guess what's the significance
9 of what's called a persistent occiput posterior?

10 A. Well, persistent occiput posterior is a hard way to
11 deliver. It's us going into the pool in a black flip. I'm
12 not saying it can't be done. And if you ever hear women talk
13 about back labor, that's what an -- kills their back because
14 the baby is pressing on their spine. So it's a very
15 uncomfortable way to deliver.

16 It leads -- it's a hard way to deliver. People do it.
17 I'm not saying -- if your pelvis is big enough, the baby is
18 small enough, the contractions are good enough, we deliver.

19 But it's a poor prognostic sign for a vaginal delivery,
20 persistence OP, meaning the baby is just -- won't rotate as
21 labor goes on, just keeps looking up at the sky.

22 Q. Okay. And how about what's known as a deep transverse
23 arrest. What's the significance of that?

24 A. Well, a deep transverse arrest is usually indicative of
25 an abnormal shaped pelvis, not a -- what we call a gynecoid

1 pelvis. And the baby just naturally comes in sideways looking
2 to the right and the left. And they -- they get into the
3 pelvis deep but looking in the wrong way.

4 And unless you are extremely competent with the use of
5 forceps, that woman is going to end up with a caesarian
6 section.

7 Q. Okay. From your experience -- do you have experience in
8 reading medical records related to labor and delivery?

9 A. Yes, I do.

10 Q. How many times have you looked at and interpreted medical
11 records related to labor and delivery?

12 A. For people other than myself --

13 Q. Or for your own patients.

14 A. For my own patients, thousands, obviously, because I've
15 delivered thousands of patients. And I'm looking at medical
16 records of thousands of people over 30 years.

17 I've also been asked -- I've been doing medical
18 malpractice reviews since the late 1980s. I've been doing it
19 for 25 years. So I've been asked clearly over a hundred times
20 to review records of other physicians who have -- physicians
21 or midwives or family practitioners, people review records of
22 people who have gone through the labor process. I've been
23 asked to do that over a hundred times.

24 Q. Okay. Now I got a two-part question. Number one is when
25 you have this arrest situation we've discussed, and you

1 mentioned it's imperative to determine the position of the
2 baby -- I guess you kind of already explained it, but real
3 quickly again, why is it important to know the baby's
4 position?

5 A. Well, when there's an arrest, that's a fork in the road.
6 Something's got to be done. The baby's stuck. You can't
7 leave a baby stuck. You just can't -- it can't be done -- you
8 know, you can't do it. Something has to happen.

9 So what are one of the things we can do when someone gets
10 stuck? We can give a drug to increase the contractions. But
11 we better know the position. We better have some evaluation
12 of the pelvis and we better have some understanding of the
13 size of the baby -- passenger, passage, position -- before we
14 increase the powers because it gets back to the desk going
15 through the doorjamb. Because if you already have adequate
16 contractions, and you start increasing those beyond adequate,
17 you're putting the mother in harm's way and you're putting the
18 baby in harm's way.

19 Q. Okay. How -- this OA, OP, how is that recorded in the
20 medical record? If it's been assessed for, what should we see
21 in the medical record?

22 A. It should be under "position". And we should be talking
23 about whether it's OA, OP, and what the station is.

24 Q. Okay. So you know how to look at a medical chart and
25 determine whether or not it's ever been assessed?

1 A. Yes.

2 Q. Okay. Now you talked about the power, maybe one of the
3 reasons the baby could be stuck is that the power is not
4 sufficient. How is it determined -- I mean, how do you know?

5 A. Okay. So there was a time, prior to 1960s, how did they
6 know where the powers were strong enough? Doctors, midwives,
7 you know, various people who facilitated women having babies.
8 They put their hands on the women's uterus and they felt, they
9 palpated the contractions. And experience would say this
10 feels mild, this feels moderate, this feels strong.

11 Then comes the 1960s and we start monitoring. We have
12 sonographic belts that can actually record the contraction
13 pattern. And then we got even better than that, because what
14 those things do is they tell us when the contractions are
15 coming, but they don't tell us how strong they are, these
16 belts. They can't measure strength. The only thing they can
17 do is measure frequency.

18 So you put the belt on and you see nice ups and downs.
19 You don't know what those ups and downs are. You can palpate
20 and say, as an experienced person, they feel mild, moderate,
21 or severe.

22 Then we got a better technology called an internal
23 pressure catheter where we actually insert something like a
24 straw. It's flexible, you know, it's rubber. And it's long
25 and thin. And we can connect it to a monitor that, when the

1 uterus contracts, it actually gives you a number. It tells
2 you how many millimeters of mercury the uterus is contracting.

3 So in a normal labor, things are going hunky -- you know,
4 everything is going smooth, baby is moving down and dilated.
5 We don't use that because we like what's happening. The baby
6 is moving, cervix is dilating, cervix is effacing.

7 But when somebody gets stuck, and we call it an arrest of
8 the active phase of labor, and we're thinking about giving a
9 drug, we're thinking about intervening and giving a drug that
10 can do a lot of potential good if the contractions are
11 inadequate, but could do a lot of potential harm if the
12 contractions are already adequate, you need to put a pressure
13 catheter in.

14 So we know, do we have -- because we know what good is,
15 we know what good powers are, and we know what not good powers
16 are. We'll probably talk about that in a minute.

17 Q. Okay. First, I guess, when you're looking at the
18 adequacy of contractions, is there an objective manner to
19 assess it using this catheter?

20 A. Yes. Because, you know, when a person puts their hand on
21 the belly and feels a contraction, that's subjective. You
22 know, mild, moderate, severe. One person's mild is another
23 person's moderate; one person's moderate is another person's
24 severe.

25 But when you put a catheter in, you get a reading from a

1 machine, assuming the machine is accurate. It's going to tell
2 you exactly how many millimeters of mercury that force is when
3 that uterus contracts.

4 Q. Okay. And what is the limit? What is the number that
5 tells us is it ineffective uterine activity or is there
6 adequate uterine activity and therefore something else causing
7 it?

8 A. So we have units, and we call them Montevideo units
9 because the gentleman, the doctor who invented it came from
10 Montevideo. That's the only reason it's named that. They're
11 called Montevideo units.

12 And we know that in a ten-minute window, we expect the
13 uterus to contract so many times at such an amplitude. And
14 what we do is -- I'm going to give you a hypothetical.

15 If the contraction starts at a zero and goes up to 75,
16 and there are three contractions in a ten-minute window, well
17 that's 200 -- we just add them up, 75, 75, 75. That's 225
18 Montevideo units. And we know there are good powers if the
19 Montevideo are 200 or greater.

20 Now if each contraction -- if one contraction is 30 and
21 one is 25 and one is 50, and we add it up and it's 130, then
22 we say, you know, the Pitocin can be extremely helpful because
23 we can bring it up to 200, see if we can get this baby out
24 vaginally.

25 But if the Montevideo units are already at 200, 225, 250,

1 you're putting the mother in harm's way and you're putting the
2 baby in harm's way by elevating the contractions above what's
3 already normal and adequate.

4 Q. Is this intrauterine pressure catheter you're discussing,
5 is it only in use at your facility?

6 A. No, it's used throughout the world. It's used throughout
7 the United States. It's used in Nebraska. It's used in New
8 York. It's used in Europe. It's used everywhere.

9 Q. Is it really expensive? Is there some big costs
10 associated with this --

11 A. I would imagine the catheter probably costs -- it could
12 cost 20, \$40, something like that. I'm not sure. It's not a
13 big -- it's a straw with a wire that you attach to a machine
14 that the facilities own.

15 Q. Is there an incredible difficulty in placing this?

16 A. No, it's easy. Interns -- in many institutions, nurses
17 place them, midwives place them. We have our medical students
18 and residents place them. It's a fairly easy thing. You just
19 thread this straw around the baby's head into the uterus.

20 Q. How many have you used in your career?

21 A. Hundreds, if not thousands.

22 Q. Have you ever had an adverse outcome because of its use?

23 A. Never.

24 Q. Is it thought to be a dangerous type of procedure?

25 A. Not at all.

1 Q. So when is it indicated? We've been talking about
2 abnormal labor. When is it indicated for use?

3 A. So it's indicated when you're in the fork in the road,
4 when you've got to decide, are we going to do a caesarian
5 section? Or we going to augment her labor? Are we going to
6 increase the P, the power? Okay?

7 So that's the fork in the road. When somebody's stuck,
8 you have one of two options: Deliver the patient or augment
9 the labor.

10 Because once you've gone beyond a certain point in time,
11 it's not safe anymore for the mother and baby. You've got to
12 cut bait. You've got to either deliver the baby or you've got
13 to augment the labor.

14 And before augmenting the labor, the standard of care is
15 to see what's going on with the contractions. And the easiest
16 thing, the simplest thing, the standard of care is to put a
17 pressure catheter in.

18 Q. Okay. You mentioned a couple things I want to talk about
19 in your answer.

20 You mentioned augment labor. What does that mean and how
21 is it different from induction of labor?

22 A. Okay. An induction of labor -- first of all, let's talk
23 about Pitocin for a minute. It's a drug that the brain
24 normally makes. And it's used -- one of the functions in the
25 body is to make the uterus contract. It has other functions.

1 It brings the milk down postpartum. But one of the things
2 that it does is makes the uterus to contract.

3 An induction is when you take someone who is not in labor
4 and for whatever reason -- there are multiple reasons in the
5 differential diagnosis, many reasons why we sometimes say that
6 it's safer to end the pregnancy rather than to keep going on.
7 A lot of different reasons. And if we're going to try for a
8 vaginal delivery, we take someone who is not in labor, give
9 them Pitocin, that's an induction.

10 An augmentation is somebody who is already in labor, but
11 we've evaluated that patient, we've decided that the power
12 isn't good enough, and that's why things aren't moving the way
13 we would like them to move.

14 And we're going to add to what the -- to the Pitocin that
15 the mother's brain is already making, we're going to give her
16 Pitocin in the IV.

17 Q. Okay. Another concept you mentioned in your earlier
18 answer was you talked about standard of care. What is the
19 standard of care?

20 A. The standard of care is what somebody of qualification,
21 what anybody would do in the community, in a similar or same
22 situation.

23 So in other words, what a competent person is expected to
24 do in the same or similar situation. That's what defines the
25 standard of care.

1 Q. Okay. And I think in Nebraska, for legal purposes, would
2 you assume if I'm talking about the standard of care or the
3 safety principles applicable to this case, could you assume
4 we're using a reasonably prudent healthcare provider in
5 similar circumstances -- in like or similar circumstances?

6 A. Yeah. I said it in a different way, but I thought that
7 was --

8 Q. And also as we're going through your testimony, if you're
9 going to give any opinion, can you agree to do so to a
10 reasonable degree of medical certainty?

11 A. Yes, sir.

12 Q. Okay. The standard of care -- are you familiar with the
13 standard of care as it applies to an obstetrician who is
14 managing a labor and delivery?

15 A. I am.

16 Q. Are you familiar with the standards of care which would
17 be applicable to labor and delivery nurses managing a labor
18 such as this?

19 A. I am.

20 Q. How?

21 A. Because that's what I do. I -- on a weekly basis, I'm on
22 labor and delivery. And I'm working with labor nurses, charge
23 nurses on labor and delivery floor. And as I said, we're a
24 team. And that's what we do.

25 So it's not only from 30 years of personal experience,

1 I'm also a board certified obstetrician/gynecologist. I read
2 a lot. I talk to people a lot. I attend national conferences
3 a lot. And so besides my individual -- and by the way, I'm at
4 an academic institution that has over 75 obstetricians/
5 gynecologists who practice. And I regularly attend
6 conferences where we review our healthcare.

7 So as a result of my experience, my board certification,
8 my reading, I know what the standard of care is as it pertains
9 to labor and delivery and the role that the healthcare
10 providers on a labor and delivery floor need -- what they need
11 to do to meet the standard of care.

12 Q. Okay. And those -- encompassed within that healthcare
13 provider would be labor and delivery nurses, correct?

14 A. Absolutely. They're an integral part of the team.
15 They're a vital part of the team.

16 Q. When you conduct these reviews at the hospital level,
17 also when you're doing forensic legal reviews like you've done
18 here, one of the things that's done is to analyze and assess
19 the care and treatment rendered by labor and delivery nurses
20 with respect to whether or not they met the standard of care.

21 A. Absolutely.

22 Q. Also, do you have grand rounds or in-hospital in-services
23 where you participate with nurses in teaching and things like
24 that?

25 A. Weekly.

1 Q. Okay. Are you also familiar with what are called
2 hospital policies and procedures that are either applicable to
3 a maternity service itself or to labor and delivery nurses?
4 Are you familiar with those?

5 A. Yes.

6 Q. Do those also help set the standard?

7 A. Yes.

8 Q. What is the ultimate purpose of these standards? Why do
9 they exist?

10 A. The ultimate purpose -- well, it's a good idea for people
11 to practice similarly because again, we have a common goal.
12 Whether we're in Nebraska, New York, California, Florida, our
13 common goal is to send people home healthy and happy. What we
14 have is experience in the field.

15 We have -- I'm not a researcher, but we do have
16 researchers who do the work. And they do studies. And they
17 look at thousands of patients, and they review thousands and
18 thousands of hospital records from multiple institutions. And
19 they come to a consensus as to what's safe and what isn't
20 safe, what's correct and what isn't correct.

21 Now, these things are not written in stone. And I would
22 agree that the standard of care can change at times as
23 information becomes available, as technology changes.

24 But you want to be -- you want to feel confident when you
25 go into an emergency room in Omaha or you go into an emergency

1 room in New York or you go into an emergency room in Chicago,
2 you're going to get the same level of care no matter where --
3 because we're all entitled to the same level of care.

4 Q. Okay. If there's an -- that's often referred to as the
5 national standard of care?

6 A. Yes.

7 Q. So is it your opinion that it is a national standard of
8 care with respect to how labor and delivery nurses should
9 handle a situation like we're going to examine here today?

10 A. Absolutely.

11 Q. Now, if there's a suggestion or an argument or a
12 statement made to the jury that there is no national standard
13 of care, it's dependent on the community you're in, that
14 there's a different standard of care, that women in labor get
15 treated differently at the Bellevue Medical Center than they
16 would in New York or Chicago or anywhere else, what would you
17 say to that?

18 A. I'd say that's ridiculous. The American Board of ObGyn,
19 they don't ask different questions of people due to what state
20 they're from. To become board certified, you take the same
21 exam -- you take the same written exam and you've got to
22 answer the same kind of questions.

23 It is true that in remote areas of the United States,
24 practices may be different than in the major -- in a city like
25 this where there are major institutions, a city like mine

1 where there are major institutions.

2 But as a general principle, as a general principle,
3 doctors have a responsibility -- healthcare providers and
4 doctors have a responsibility to our patients. And our
5 responsibility is to set a standard that wherever you live,
6 you have an expectation that you're going to get cared for in
7 that manner.

8 Q. Okay. Are there textbooks and articles that are
9 published that would only be applicable to outside of the
10 Bellevue Medical Center?

11 A. No.

12 Q. Okay. I'll just jump back. I forgot what I was going to
13 get into.

14 You mentioned earlier Pitocin. Is Pitocin a safe
15 medication? I made a representation that it is a high-alert
16 medication in opening statement.

17 A. Right.

18 Q. Counsel said it's safe. Which is it? Talk about that.

19 A. It's both. You are both right because when used
20 correctly, it's a safe and terrific medication because it can
21 help lower caesarian section rate. It can take somebody who
22 is not having effectual contractions, you give it to them and
23 as a result of giving Pitocin, they have a vaginal delivery, a
24 healthy baby, a healthy mom. What could be better?

25 It's also a very dangerous drug if it's used

1 inappropriately. Like most things in life, if you use it
2 correctly, it's a wonderful tool. If you use it incorrectly,
3 it can be incredibly dangerous, and for the reasons I've
4 talked about and I won't repeat it again. If you use it
5 inappropriately, you put both mother and baby in harm's way.

6 Q. Okay. I was going to talk about two concepts. And I
7 guess in this case, because it's relevant to it, the
8 particular application to Pitocin. What is an indication?
9 Generally what is an indication with respect to Pitocin?

10 A. Indication for Pitocin?

11 Q. Indication. What's that mean and how --

12 A. Induction of labor and augmentation of labor. We've gone
13 over the augmentation. It's a power -- if there is a power
14 problem in the labor that causes the baby to get stuck, if you
15 determine that there is ineffectual contractions and that's
16 the reason that the baby isn't coming, that's the number one
17 indication for Pitocin; ineffectual contractions.

18 Q. Okay. And what is a contraindication? What does that
19 mean generally?

20 A. A contraindication means it's dangerous to use and should
21 not be used in the setting that you're thinking about using it
22 in.

23 And there are many contraindications for the use of
24 Pitocin. Someone who has unexplained vaginal bleeding because
25 if someone has an abruption of the placenta, the placenta

1 separating, you don't want to use Pitocin.

2 If somebody has -- I'm going to use a term I haven't used
3 yet today. If someone has cephalopelvic disproportion, in
4 other words, the baby's not going to be able to fit through
5 the pelvis, regardless of how much power you -- no matter how
6 much you put your foot on the pedal, that baby is not going to
7 come through, that's a contraindication.

8 So you have to rule out cephalopelvic disproportion
9 through all those Ps that we've talked about to make sure that
10 you don't cause the uterus to just be contracted which causes
11 a uterine rupture, which happens as a result of the
12 inappropriate use of Pitocin, or damaging a baby, which can
13 happen as a result of continued uterine contractions that are
14 not resulting in movement of the baby. And the baby is just
15 stuck in the pelvis.

16 Q. Okay. You mentioned cephalopelvic disproportion. Is
17 there an abbreviation that you use?

18 A. CPD, yes.

19 Q. Break down that phrase. What does it mean?

20 A. It means the baby is stuck. It's that simple. It means
21 one of the powers is off, either the pelvis is too small, the
22 baby is too big, or some combination of the two, or the
23 position isn't right. That's cephalopelvic disproportion.

24 Q. Okay. Is it sometimes referred to as fetal pelvic
25 misfit?

1 A. I'm sure. I don't like -- I don't like "misfit". I
2 don't like that term, but I'm sure somebody uses that.

3 Q. Okay. But it's the same concept?

4 A. Yes. It's really -- it's no more complicated than we've
5 got a stuck baby.

6 Q. We talked about abnormal labor to some degree. You
7 talked about abnormal dilation. What is arrest of that? I
8 think you got into it a little bit, but explain more about
9 what that means and how it's diagnosed.

10 A. So once somebody's gone into the active phase of labor --
11 my personal belief, that's 4 centimeters; somebody may say 5,
12 somebody may say 6. The most extreme data says you can wait
13 until 6, okay? I say the majority of the community of ObGyns
14 in the country agree that 4 is the right number. But 5 and 6
15 are acceptable, okay?

16 But once somebody gets stuck at 6, that's an arrest. And
17 once they're stuck for two hours with good contractions,
18 that's the definition of an arrest of the active phase of
19 labor. That's the definition.

20 Q. How about -- well, you talked a little bit about station
21 again. What's the -- what's the significance of the situation
22 where you have an arrest and the station is high, remaining
23 above the zero station, or not descending into the pelvis?

24 A. That's one of those yellow flags. Because, I mean, think
25 about it. The baby's stuck and you're not happy with how low

1 the baby is. I mean, I call that a yellow flag. I don't say
2 it's an absolute indication to stop, you know, and do a
3 caesarian section. But you've got to say to yourself, you
4 know, the cervix has all of a sudden stopped dilating. It
5 stopped effacing. And the baby has stopped descending into
6 the pelvis.

7 And I told you that the majority of women having their
8 first baby, they start at a zero station. They start with the
9 baby engaged. That's what nature -- that's how nature planned
10 it, okay?

11 So if you're above zero station and in the active phase
12 of labor, you're 5, 6, 7, 8 centimeters, and you're above zero
13 station, that's not -- you know, we're not happy with that.
14 I'm not -- and I'm not saying in the world, you know, that
15 that person can't deliver vaginally. I'm not saying that.
16 What I'm saying is that's a troubling sign.

17 Q. How do you measure station?

18 A. Again, that's a pelvic exam. And that's also something
19 that, you know, has tremendous amount of variability from
20 examiner to examiner.

21 Q. What is caput?

22 A. That's exactly -- so what happens is, as the baby
23 descends into the pelvis, the soft tissue -- just talking
24 about the soft tissue. The soft tissue of the head starts to
25 swell, okay?

1 And you can get -- you know, it's like -- I don't know if
2 any of you lived through the '70s the way I did, if you
3 watched Saturday Night Live, the Coneheads, the babies looked
4 like Coneheads because their soft tissue gets elongated.

5 And you've got to be really careful when you're
6 evaluating stations because we don't care about the descent of
7 the soft tissue. That has no impact on station. We care
8 about how the bones are descending, because we're not trying
9 to deliver the soft issue of the scalp, we're trying to
10 deliver the head of the baby.

11 So many times people feel the soft tissue and they
12 confuse that oh, the baby is making progress. The only thing
13 that's making progress is the soft tissue turning into a cone.
14 Q. Okay. Now I want to talk about -- a little bit --
15 introduce the concepts of labor monitoring. We're going to
16 look at the records here once we get through the general
17 concepts so we know what we're looking at.

18 A. Sure.

19 Q. But what are the elements, what are the essence of
20 monitoring a labor?

21 A. So when you monitor labor, you got two patients. You've
22 got to monitor the mom and you've got to monitor the baby.

23 How do you monitor the mom? You check the vital signs.
24 Make sure the blood pressure is okay, make sure the
25 temperature is right, check the pulse. Make sure these are

1 okay. Asking how she's doing in terms of pain management.
2 That's monitoring the mom, making sure everything is okay with
3 her.

4 How do we monitor the baby? There are a couple of ways
5 to do it. One way that was done in the birthing center in
6 this particular case is through listening with an instrument.
7 There are various instruments. We have stethoscopes you can
8 listen with. We have Dopplers you can listen with. These
9 little sonar instruments you can listen with.

10 And you put your hand on the mom's uterus every time
11 she's contracting. So you can do it without a monitor. And
12 that's okay in a normal labor and everything's moving okay.
13 No problem with that, where you listen periodically, you
14 palpate periodically, and that's the way to evaluate the baby.

15 Then the other way to evaluate, how most institutions
16 outside of a birthing center do it, is with some combination,
17 either external fetal monitoring, like I told you about before
18 where you put a belt on the woman's abdomen, and you -- and
19 the machine records the mother's heartbeat and the frequency
20 of the uterine contractions.

21 Or when things aren't going so well, and we want more
22 information than that monitor can supply, we use internal
23 catheters to get accurate numbers on exactly what's happening
24 with the uterus. And even sometimes we put a scalp electrode
25 on the baby so we can get a direct EKG of the baby rather than

1 just an indirect listen to the baby.

2 Q. Okay. So there's a couple concepts there I just want to
3 talk about a little further because they'll have applicability
4 when we look at this later.

5 If something arises -- and we talked about the need for
6 having to place the intrauterine pressure catheter in and that
7 measures uterine contractions, correct?

8 A. Yes.

9 Q. Does that measure anything about the heart rate?

10 A. No.

11 Q. Okay. So if you're curious about the power, you can put
12 the pressure in -- the catheter in, but that won't tell you
13 anything about the heart.

14 A. That's correct.

15 Q. Okay. Now, in this situation where a nurse is charting
16 that she can't tell what the baby's heart rate is, the
17 monitor's not working, or she's losing the fetal heart rate
18 with every contraction or pushing, what should be done in that
19 situation?

20 A. And that happens because, you know, when the uterus is
21 contracting in the last stage of the baby's moving, sometimes
22 it can be hard to follow the heartbeat of the baby as the
23 baby's moving around.

24 And so what we do is we put a little clip on the baby's
25 head. And that clip directly monitors the baby's heart rate.

1 And it's called a scalp electrode. And there are very few
2 contraindications. We use them all the time. We've done
3 thousands of them. It's safe. And it just is applied to the
4 baby's scalp and attached to a machine. And then, no matter
5 where the baby -- you can take all the belts off, you don't
6 need belts anymore. And it's constantly -- wherever the baby
7 is, it's picking up the baby's heart rate.

8 Q. Okay. Now because we're going to be looking at stuff.
9 How -- let's just take the contractions first. If the
10 contractions are being recorded by the external or the
11 internal belt, how are they displayed? How do you get any
12 information?

13 A. So we're using an -- we're talking about an external
14 monitor?

15 Q. Sure.

16 A. So that's a sonographic machine. That is picking up --
17 it's called a transducer. And it's picking up the
18 contractions by placing the transducer directly on the uterus.

19 And we have a graph. And what it shows is every time
20 there's a contraction, you see a little hill. And then it
21 comes down. And then you see another hill when there's
22 another contraction, and it comes down.

23 And what that's doing is that machine is able to tell
24 when the uterus is contracting. Doesn't tell you how hard the
25 contractions are; doesn't tell you anything about the strength

1 of the contractions, it just tells you the timing and the
2 frequency of the contractions.

3 Q. Can you get an idea of how long they're lasting?

4 A. Yes.

5 Q. And can you get an idea of how much rest the baby is
6 getting in between?

7 A. Yes. Not as accurate as an internal monitor; but yes,
8 you can get an idea.

9 Q. And I'll talk about those in a minute. I just saw my
10 notes.

11 One thing I forgot to ask you is a term we might hear
12 throughout is dystocia. What is dystocia?

13 A. Dystocia means that something is not fitting. It's not
14 too dissimilar to cephalopelvic disproportion. There's a
15 discrepancy inside. Something is not fitting through
16 something. It's really just another way of saying CPD,
17 cephalopelvic disproportion.

18 Q. Okay. Let's just talk about contractions in general.
19 You talked about what a contraction is. How does a
20 contraction affect the oxygen to the baby?

21 A. So we have to talk for a minute about how the baby gets
22 oxygen, okay? And the baby has a -- the most important organ
23 for this exchange of oxygen to the baby is something called
24 the placenta. So how it works is the mother's blood supply
25 goes to the placenta. From the placenta, you have an

1 umbilical cord. From the umbilical cord, which has vessels in
2 it, it goes to the baby.

3 So the placenta is like the heart and lung of the baby
4 because it's where the exchange of oxygen occurs. And without
5 a placenta, there is no -- if something happens to the
6 placenta, that's devastating, that's life threatening to the
7 baby, the various placental diseases.

8 So what happens during a contraction is before the mom's
9 blood vessels get to the placenta, they course through the
10 muscles of the uterus. So when the uterus contracts, it
11 constricts those blood vessels. You know, like the hose when
12 you're watering the lawn, it constricts it.

13 So when you constrict that, it constricts the blood to
14 the placenta, which constricts the blood flow to the umbilical
15 cord which constricts the blood flow to the baby.

16 Now when you have a nice rhythm, when you have a
17 contraction, it's a little bit of constriction. And then you
18 have a rest and the baby gets a rest for a couple of minutes.
19 And then the contraction comes. Nature built us to tolerate
20 all of that, okay?

21 So as long as we have a nice contraction pattern, that
22 level of stress that the baby experiences during the
23 contraction is -- the baby recovers. It's a recovery when the
24 contraction is over and there's a waiting time before the next
25 contraction.

1 Q. So are there scientific principles or safety principles
2 built in to look at and assess contractions to know if there's
3 any -- if they're potentially causing harm to the baby?

4 A. Yes. We know, especially -- what we are especially
5 careful about is we're manipulating the contractions. It's
6 one thing when someone has spontaneous contractions. But when
7 we're manipulating the contractions with Pitocin, we're
8 concerned about -- let me tell you the things we're concerned
9 about.

10 We're concerned about the frequency of the contractions.
11 We don't want them to come too fast because we want the baby
12 to be able to recover. We're concerned about the duration of
13 the contractions. We don't want it to occur too long for
14 obvious reasons because during that contraction period, the
15 mother's vessels in the uterine wall are being constricted.

16 We want the duration in between the contractions to be
17 adequate because that's the resting time. It's like when
18 you're talking about a prizefighter. That's when the bell
19 rings and the fighter gets to rest for a couple minutes before
20 he gets up again and takes another hit, you know, during the
21 fight.

22 So we know we're looking not only at frequency, we're
23 looking at intensity, we're looking at duration, and we're
24 looking at the resting time in between the contractions.

25 Q. If there is an intrauterine pressure catheter in, is all

1 that known with the greatest degree of certainty to the
2 hospital?

3 A. Absolutely.

4 Q. Okay. And how does that differ from when it's external?

5 A. So when it's external, you still know -- if it's a good
6 external monitor, we can pick up the frequency. As I told you
7 before, we don't know anything about the intensity because
8 those external monitors are not designed to pick up intensity.

9 We sort of get an idea of the duration because we can see
10 the pattern of the contraction. And we get somewhat of an
11 idea of the resting time in between the contractions.

12 So the most important piece of information that we lose
13 with an external versus an internal is the intensity of the
14 contraction.

15 Q. What is resting tone?

16 A. So resting tone, some uteruses completely relax. That's
17 what we want to happen in between contractions. Muscle
18 contracts, then relaxes, contracts.

19 Some uteruses don't completely relax in between the
20 contractions. And you can well imagine, why are we concerned
21 about that? We're concerned about that because if there's
22 some element of constriction in between the contractions,
23 there's some element of constriction of the mother's blood
24 vessels that are coursing through the uterine wall. So
25 there's some element of oxygen deprivation going to the baby.

1 So in the ideal world, we want good, strong contractions.
2 We want them to happen. We want the uterus to completely
3 relax. We want some resting time in between the contractions.
4 And then we want it to start all over again.

5 Q. Okay. What's the concern if contraction durations are
6 lasting longer than 60 to 90 seconds?

7 A. It's not healthy. In other words, we're just not built
8 for that in utero. We're not built for that kind of time of
9 maternal vessel constriction to go on. It's not good for the
10 baby.

11 I'm not saying -- as soon as it happens, does the baby
12 get into trouble immediately? No. It's a stress on the baby.

13 And depending on how long that goes on for and how
14 intense that is, and with some biologic variabilities that
15 some babies can tolerate more stress than others, you're in an
16 area that you can potentially do harm to the baby.

17 Q. Similarly, with respect to the resting time, what's the
18 harm or the concern when the resting time is less than 60
19 seconds between contractions?

20 A. Same reason when the duration of the contraction is more
21 than 60 to 90 seconds. When you don't give the baby enough
22 time to recover, when that mom isn't supplying really good
23 oxygen, the baby's running a little marathon inside. And what
24 it really wants all the time during labor is oxygen.

25 Any opportunity when you're depriving the baby of oxygen

1 in any way by diminishing the resting time in between, by
2 expanding the duration of the contractions, that's having some
3 impact on the baby. And depending on how long you let that go
4 on for will determine what ultimate effect it will have on the
5 baby.

6 Q. Okay. And if the frequency of contractions -- first of
7 all -- how are -- I guess you explained how resting time is
8 measured and how duration is measured. How is frequency
9 measured?

10 A. Frequency is measured by an external monitor, as well as
11 an internal monitor can measure frequency because that's what
12 it's designed to do. You look at the strip. There's an up,
13 there's a down. That's the frequency. You count in a
14 ten-minute window how many contractions you have.

15 Q. Okay. And what's the harm if the frequency of
16 contractions is greater than every two minutes?

17 A. It's the exact same thing we talked about; same thing
18 about duration, about length of resting time. If the
19 contractions are coming too frequently, obviously the resting
20 time is shorter. You can't get -- you know, if you're
21 increasing the frequency of the contractions, you know, simple
22 math is you must be decreasing the amount of resting time.

23 And during the contraction, the baby's being -- getting
24 diminished oxygen. And now you're creating that more
25 frequently and you're giving the baby less and less time.

1 It's like saying to the fighter, "Now instead of you having
2 two minutes in between rounds, you only get 30 seconds. And
3 we're going to expand the length of the round from three
4 minutes to six minutes."

5 Q. Okay. Are these principles, these safety standards that
6 we're just discussing, the times relevant to contractions, are
7 nurses aware of this?

8 A. They have to be aware of it.

9 Q. And did you read the depositions of the two particular
10 nurses who cared for this labor and delivery?

11 A. I did.

12 Q. And are they aware of these principles that if the
13 contractions are too excessive, they can diminish the oxygen
14 to the baby?

15 A. They are.

16 Q. Talk about -- I think you might have mentioned it a
17 little bit before, but where this arises, where there's --
18 what's the term for it when you have these types of
19 abnormalities occurring?

20 A. Now we're talking about jargon again, just words.

21 So the National Institute of Child Health and Human
22 Development, the Eunice Shriver Center, established some
23 definitions. And we -- most of the time, we follow those
24 definitions.

25 And tachysystole is one of the words that they came up

1 with. And what that is is more than five contractions in a
2 ten-minute window. That's what defines tachysystole.

3 Q. Okay. So tachysystole is a term that only focuses on the
4 frequency element of the safety rules we just discussed?

5 A. It's one of the several things that need to be evaluated.
6 They're just simply talking about frequency. They're not
7 talking about the duration of the contractions, they're not
8 talking about resting tone and they're not talking about the
9 length of rest in between the contractions.

10 Q. Okay. Are you familiar with the term "hyperstimulation"?

11 A. Yes. Long before we talked about tachy- -- in 2008 when
12 the NICHD, the National Institute of Child Health and Human
13 Development, established tachysystole, we always called it
14 hyperstimulation. I must say, some of us weren't probably
15 politically correct? We still use the word hyperstimulation.
16 We all know what we're talking about, whether it's hyper-
17 stimulation or tachysystole. It's the same word, it's the
18 same definitions. It's more than five contractions in a ten-
19 minute window.

20 Q. Okay. So there's a term now -- and you mentioned a paper
21 that was written in 2008 that defined we're going to call
22 contractions that are more frequent as tachysystole. Has
23 there been any such term to reach that tells you what you call
24 a contraction that's longer than 60 to 90 seconds?

25 A. Yes. Those are -- we call those tetanic contractions.

1 Actually the Eunice Shriver Center didn't bother to make that
2 definition for whatever reason. But in the community of
3 obstetricians/gynecologists, we call that tetany where the
4 contractions are lasting too long. And actually many times
5 what happens when they last too long, they couple one on top
6 of the other.

7 Q. Okay. You kind of mentioned two things. What is the
8 difference between tetany and coupling?

9 A. Well, coupling is more than one contraction -- okay? --
10 that overlap each other. In other words, before the
11 contraction is over, the next contraction is already starting.
12 So in other words, there's been zero resting time; that the
13 contraction isn't complete before the next contraction has
14 started. We call that coupling.

15 Q. So whether people want to splice hairs, a tetanic
16 contraction versus a coupling contraction, is there any
17 difference in the risk to the baby?

18 A. No, it's the same thing. It's contractions, whether a
19 single duration is too long, or two of them are on top of each
20 other, the end of the game is the same. The baby is being
21 deprived of blood flow; and because it's deprived of blood
22 flow, it's getting less oxygen.

23 Q. And we talked about a special term for frequency that's
24 been recognized and published, tetany and coupling that
25 weren't in that particular paper, but is there a way to

1 describe or a term that's used to describe when the resting
2 time is simply too short, not the 60-second minimum required
3 for reoxygenation?

4 A. I can't think of -- a particular term?

5 Q. Yeah.

6 A. No.

7 Q. Okay. And just because it doesn't have a fancy word like
8 tachysystole, does the -- when the rest is not at least 60
9 seconds, is it any less of a concern for the baby because it
10 doesn't have a term to call it?

11 A. Yeah. We don't have to define every element of what we
12 see. In other words, we describe what we see. We say the
13 contractions are occurring at this frequency, they're lasting
14 this long, they're in deterioration -- the time between the
15 contractions is, you know, 60 seconds, 90 seconds. And we
16 know babies need good time in between the contractions, they
17 need nice quick contractions to get them over. We don't want
18 to see coupling; we don't want to see tetany.

19 Q. Okay. And we haven't looked at the medical records yet,
20 we haven't gotten to specific facts of this case, we're just
21 talking about the concepts.

22 But when we look at charting and assessments of the labor
23 as we're moving through it, these are the things that should
24 be being assessed and thought about by labor and delivery
25 nurses who are managing labor and delivery.

1 A. Absolutely. Those -- remember, there is no obligation
2 for the primary healthcare provider, whether it be a midwife
3 or doctor, to be in the room at all times. There is no
4 obligation.

5 But we rely on the nurses to understand fetal monitoring;
6 to understand when there's a problem; to act if there's a
7 problem; and at the very least, if it's an emergency, act; and
8 if it's not an emergency, bring it to the attention of the
9 person who would want -- whether it be a midwife or a doctor,
10 would want to change what's going on. We rely on them.
11 They're an integral part of the team.

12 Q. When you have this evidence of excessive uterine activity
13 that's potentially injuring the baby through decreased oxygen,
14 and the labor's having Pitocin being administered at the same
15 time, what's the standard or the safety rules applicable to
16 that situation? How do they work?

17 A. That's really -- you know, the number one thing we
18 promise in medical school is to do no harm. And if we're
19 giving a drug that's hurting somebody, you stop the drug. The
20 beautiful part about Pitocin, the half-life of Pitocin is a
21 minute and a half.

22 So when you turn off the Pitocin, it gets out of the body
23 really quick. Some drugs you take it and can't get rid of it
24 for hours and hours; some of them, even days. You buy these
25 long-acting cold remedies, you can't just stop them because

1 they're designed to last in your body for 24 hours. Pitocin,
2 you turn it off, the half-life is a minute and a half. By six
3 minutes, it's gone.

4 So your contractions are occurring too frequently, you're
5 not getting enough rest in, the duration is too long, you shut
6 the Pit off. That's what you do. Or, if you're at a high
7 dose of Pit, you turn the Pit down at the very least; turn it
8 down, shut it off. In this particular case, there is a very
9 low dose to begin it. Shut it off. Some people are
10 hypersensitive to low doses so they start at a low dose. Some
11 people take huge doses. If you get to the point it's too
12 much, we cut back. But there's a term called iatrogenic
13 meaning that we, as healthcare providers, are creating the
14 problem. We're the ones that are creating the problem. And
15 when you're giving -- when you have a normal tracing, and you
16 give Pitocin, and 20 minutes after you give Pitocin, you go
17 from a normal tracing to a not normal tracing, you've got to
18 ask yourself, "Did I do this? Am I potentially doing harm
19 that I promised not to do?" Cut back. Stop it. Do
20 something.

21 Q. Okay. You mentioned a couple concepts there I want to
22 just talk about.

23 Levels of Pitocin, you mentioned there can be high
24 protocol to lower dose protocol. And then you also mentioned
25 hypersensitivity.

1 A. Right.

2 Q. Talk about how that interplays with -- how Pitocin works.

3 A. So you never know until you start giving Pitocin to
4 somebody how they're going to respond to it because we're all
5 different. We're all built a little bit differently.

6 So the average woman responds to 11 milliunits of
7 Pitocin. That's when we start seeing that we're having an
8 impact on their contraction pattern. Some people require 20.
9 In this case, this particular person responded to two
10 milliunits.

11 So the standard protocol, we move really slowly. Why do
12 we move slowly? Because we know it's dangerous when it's not
13 used properly. I mean, if it wasn't a dangerous drug, we'd
14 just zip, you know, give a bunch of Pitocin, see what happens.

15 But we start off at two milliunits. That's a standard
16 throughout the United States, one to two milliunits, which is
17 one-fifth of the dose that the average person responds to.

18 And we go up with the Pitocin, if we don't see a response
19 with two milliunits, every 20 to 30 minutes, by two
20 milliunits. So it's standard of care throughout the United
21 States to take two and a half to three hours to build somebody
22 up to the average dose of the person that responds because
23 we're so careful that we don't want to do any harm. That's
24 how careful we are.

25 We already know the average person responds to 11. We

1 don't give 11. Most institutions, we start at two and go up
2 by two every 20 to 30 minutes.

3 Q. So we talked a bit about adequate uterine activity. If
4 someone -- I want to just talk about reasonable nursing
5 judgment and what would be reasonable and what would not be
6 reasonable and why.

7 If a labor is running, and a mother is at 2 milliunits of
8 the Pitocin, and the contraction pattern is not only adequate
9 but demonstrating the overactivity we talked about that places
10 the baby at risk, would it ever, under any circumstances, be
11 prudent to increase the dose?

12 MR. WELCH: Objection. Your Honor, it's improper
13 hypothetical, no facts in this case.

14 THE COURT: Well, we can have a sidebar. I don't
15 know what the facts in the case will demonstrate.

16 Mr. Cullan, is it your position that the facts will
17 demonstrate the Pitocin was increased?

18 MR. PATRICK CULLAN: Yeah. Is there a dispute that
19 the Pitocin was increased?

20 MR. WELCH: That's -- your question --

21 THE COURT: Let's have a sidebar.

22 (Bench conference on the record.)

23 THE COURT: What is the objection?

24 MR. WELCH: My objection is it's calling for a
25 hypothetical on the part of this witness. There are not

1 sufficient facts that have been demonstrated in this case that
2 the hypothetical as posed to this witness are the facts of
3 this case. And it would be highly prejudicial to the
4 defendant if those facts are not elicited if it's a proper
5 hypothetical. He's just throwing concepts out there and
6 saying would it, under any circumstances, not be appropriate.
7 And I think if you're going to do hypotheticals, you have to
8 do it with the facts of this case.

9 THE COURT: Let me inquire first of you, Mr. Welch.
10 Is there a dispute that the Pitocin level was increased after
11 the initial dosage was administered?

12 MR. WELCH: No.

13 THE COURT: Okay. Overruled.

14 (End of bench conference.)

15 THE COURT: We're back online.

16 Mr. Cullan, the objection's overruled. If you wish to
17 restate your question, you may.

18 MR. PATRICK CULLAN: Can I have it read back?

19 THE COURT: Ms. Fauber, we will ask you, please, to
20 read it back.

21 COURT REPORTER: If a labor is running, and a mother
22 is at 2 milliunits of the Pitocin, and the contraction pattern
23 is not only adequate but demonstrating the overactivity we
24 talked about that places the baby at risk, would it ever,
25 under any circumstances, be prudent to increase the dose?

1 A. Never.

2 BY MR. PATRICK CULLAN:

3 Q. Why?

4 A. Because if you're getting an adverse reaction, you're
5 getting, you know, a complication from giving medicine, giving
6 more medicine is only going to add to the complication. You
7 would anticipate that if somebody is contracting too
8 frequently with two milliunits, they're going to -- it's just
9 going to be worse when you give them four milliunits.

10 Q. Okay. If a nurse was really watching and assessing
11 carefully a laboring mother and that was the situation, and
12 she did, in fact, increase it to four, what significance would
13 that be to you as a physician?

14 A. If a nurse saw that the contraction pattern was not safe
15 for the mother and the baby and she increased the Pitocin,
16 that nurse would be deviating from good and acceptable
17 practice.

18 Q. Okay. And so I just want to be clear. If the
19 contractions are noted to be every minute and a half -- the
20 frequency of the contractions, every minute and a half to four
21 minutes lasting 60 to 70 seconds -- and we haven't talked
22 about the heart rate pattern so let's just deal with that --
23 and the Pitocin is running at two milliunits, and it's
24 increased to four, based on that information, is there any
25 reasonable rationale for that to happen?

1 A. There is no --

2 MR. WELCH: Let me interpose an objection to the form
3 of the question.

4 THE COURT: Overruled. He may answer.

5 A. There is no safe rationale. There is nothing safe about
6 increasing Pitocin with the information that I just heard.

7 BY MR. PATRICK CULLAN:

8 Q. We haven't talked about heart rate yet. Let me
9 think -- we haven't gotten there yet.

10 But if that same factual circumstance I just represented
11 to you was true, and the fetal heart rate was a Category II,
12 which we've not talked about yet, but it's indeterminate,
13 would that be prudent healthcare?

14 A. No, it's cause and effect. So if you have an abnormal
15 contraction pattern, the effect of that is going to be
16 something -- you're going to have evidence that the baby is
17 under some level of stress, some level.

18 And so if you're creating a situation but stressing the
19 baby, you're seeing it. You go from a normal heart -- a
20 normal contraction pattern and a normal heart rate and a
21 reassuring heart rate to an abnormal contraction pattern and
22 an indeterminate heart rate pattern where you no longer say
23 it's reassuring, the ABCs of medicine are what you're doing is
24 having a negative effect. And the standard of care is to stop
25 what you're doing.

1 Q. Okay. Maybe it's a good time to shift gears. I want to
2 talk a little bit more about contractions in a minute, but
3 let's just address -- so we've talked about how you monitor
4 the contractions. What's the other monitoring for the fetal
5 side of the equation?

6 A. The fetal side, we look at the heart rate. And what's
7 interesting about the heart rate, it's not just the beating
8 heart. They're -- the heart rate of the baby is controlled by
9 the autonomic nervous system of the baby.

10 So it's not just that the heart is beating, it's that the
11 brain, the spinal cord, all the endocrine organs of the baby
12 are all telling the heart how to beat. So in order to have a
13 normal heart rate, you have to have a healthy, intact central
14 nervous system.

15 And if the central nervous system is being stressed --
16 and the most common reason to be stressed in labor is from
17 oxygen deprivation by decreasing the amount of oxygen -- that
18 will change the heart rate pattern.

19 So when we talk about heart rate patterns, don't just
20 think of it as a single organ, that we're just looking at the
21 heart. When we look at the heart, we're looking at the
22 central nervous system of the baby because we know that the
23 central nervous system of the baby is the most sensitive to
24 oxygen deprivation. The last thing we want to do is damage
25 the brain of the baby.

1 And we know that changes in the status of the brain of
2 the baby will change the status of what we see on the heart
3 rate pattern.

4 Q. Okay. How is the heart rate pattern -- sorry, strike
5 that.

6 How is the heart rate displayed so that it can be
7 assessed by the healthcare professionals who are caring for
8 the labor?

9 A. We're going to see that pretty soon. It looks like an
10 EKG, like an adult EKG, if any of you have ever had that. We
11 put a monitor on, whether it be internal or exterior, and we
12 watch the ups and downs of the heart rate.

13 And again the whole pattern of what we see, we're going
14 to get into it, I'm sure. The patterns we see -- you have to
15 remember this throughout the day today -- what you see on the
16 heart rate is a function of the central nervous system. That
17 is to say, the heart doesn't act independent of the central
18 nervous system. So any oxygen deprivation to the central
19 nervous system will ultimately have an impact on the fetal
20 heart rate.

21 Q. Okay. And just quickly, if you can -- so with the heart
22 rate, we may hear concepts like accelerations, what are those?

23 A. The good thing is when you excite the baby for whatever
24 reason, the heart rate goes up. It's like when we get -- you
25 know, when we run or a loud noise goes off, our heart rate

1 goes up a little bit. And again, that's our central nervous
2 system telling our heart and our endocrine system, pouring out
3 a little cortizone, saying, noise, run, you know. And we
4 expect the baby to do the same thing. So accelerations are
5 reassuring signs that the baby is responding to the
6 environment appropriately.

7 Q. What are decelerations?

8 A. So there are different kinds of decelerations. Some of
9 them we anticipate in labor, but some of them, as I'm sure
10 we're going to get into, are a sign of a lack -- that the baby
11 is not getting sufficient oxygen.

12 And what we're concerned about is the frequency of them.
13 An isolated deceleration of the heart rate is not the end of
14 the world. When they start to become repetitive, we start to
15 get nervous about that.

16 And the depth of the deceleration is something we get
17 nervous about, and the shape of it. And as experts in reading
18 fetal heart rate monitors, we look at the frequency of them,
19 we look at when they happen in relation to the contraction. I
20 said frequency, relation, and the depth of them.

21 And again, these are all things that are telling us how
22 much stress this baby is tolerating during this labor process.

23 Q. Okay. And what is a prolonged deceleration, and what's
24 the significance of that physiologically?

25 A. So a prolonged deceleration, by definition, is when the

1 heart rate of the baby goes down from its baseline for greater
2 than two minutes but less than ten minutes, 15 beats.

3 And the significance of that -- that's a significant
4 event, the prolonged deceleration. And generally what comes
5 -- remember we talked about differential diagnosis before.
6 And our differential diagnosis of a prolonged deceleration is
7 oxygen deprivation. We're asking ourselves what has happened
8 here to reduce the oxygen to the baby that's caused it to have
9 such a significant deceleration.

10 Q. When any of these -- I guess strike that.

11 Variability is something we're going to talk about a
12 little bit with the heart rate. What is variability and what
13 significance does it have?

14 A. So variability is the ups and downs. When you watch a
15 baby -- a heart rate, the last thing you want to see is
16 something that looks like someone took a pen and just sort of
17 went across the line.

18 You want to see variability in that heart rate. That's
19 what our nervous system tells the heart to do. So we have
20 this variability of a couple beats per second. One minute
21 it's 120, then 118, then 124. If it's 120, 120, 120 all the
22 way through, that's a very depressed central nervous system.

23 So one of the elements we look at is not only
24 acceleration and deceleration in the actual heart rate, we
25 look at the variability of the heart rate, once again telling

1 us the oxygen status of the baby.

2 Q. What is the significance of absent variability?

3 A. Absent variability is the worst it gets. We have
4 categories of fetal heart rate monitoring, depending on
5 what -- if we see accelerations, if we see decelerations, what
6 kind we see.

7 And the worst category of all is absent beat variability.
8 That's a baby that's in dire -- that's an obstetrical
9 emergency, absent beat variability is an obstetrical
10 emergency. At that point, the clock is ticking.

11 Q. Okay. Sticking with variability, what is the baseline?

12 A. So baseline is -- you look at the heart rate over a
13 ten-minute period and you average it out.

14 So like I said, there's variability. So it could --
15 let's just take as an example, you see 118, 122, 124, back to
16 118. You look at it over ten minutes and you call a baseline.
17 Say the baseline is 120. You base everything you're going to
18 talk about -- because you can only talk about an acceleration
19 or a deceleration if it's above or below a baseline. So you
20 have to start with a baseline. So it's what we compare
21 everything to.

22 So we start with a baseline. We establish what the heart
23 rate, how many beats per minute by looking at not one minute,
24 we look at ten minutes. And then we decide if there are
25 accelerations or decelerations around that baseline.

1 Q. Okay. So all these components we've talked about,
2 accelerations, decelerations, variability, and baseline, go
3 into categories; is that true?

4 A. Yes.

5 Q. Walk us through the categories, what they are and what
6 they mean.

7 A. So categories tell us what the status of the baby is. So
8 a Category I tracing is to a 99 percent probability a healthy
9 baby. It's a baby with a normal baseline. It's a baby that
10 doesn't have what we call variable or late decelerations. It
11 could have accelerations or not. And it has good beat-to-beat
12 variability -- the beat-to-beat variability is above five
13 beats per minute -- five beats per second, excuse me. So
14 normal beat-to-beat variability, normal baseline, lack of
15 decelerations. And that's a Category I tracing.

16 A Category III tracing is as bad as it gets. That's that
17 -- you take a ruler, and it looks like someone -- there's no
18 variability. There's absent beat-to-beat variability. And
19 with that, you either have repetitive late decelerations --
20 one of the kinds of decelerations we're going to talk about --
21 repetitive variable decelerations. You could have something
22 called sinusoidal pattern. So it's the worst you get.

23 And then you have something in the middle called a
24 Category II tracing. And a Category II tracing simply is
25 defined as not a Category I or a Category II -- or III, excuse

1 me. It means it's indeterminate. You're not reassured, but
2 you're not scared out of your mind that the baby's in trouble.
3 You haven't determined what's going on.

4 Q. So it's a gray area?

5 A. It's a gray area.

6 Q. A question mark.

7 A. Excuse me?

8 Q. A question mark.

9 A. It's a question mark. In other words, the goal when you
10 have a Category II tracing is to move it into the Category I.
11 And you hope you're not seeing it shift closer to a
12 Category III.

13 Q. After if Category II tracing arises and Pitocin is being
14 running, what should be done?

15 A. The simplest thing is cut it down if you've giving high
16 doses; stop it if you're giving low doses. It's so simple.

17 Q. Okay. And why?

18 A. Because we're advocates for the mother and baby. And if
19 you're -- the telltale sign that you're in trouble of doing
20 what you promised not to do, to do no harm, is when you see
21 this transition, you start out with a beautiful baby with a
22 Category I tracing. And you go to this indeterminate zone,
23 this Category II. And God forbid you go to Category III.
24 That's physical evidence that you're watching a baby getting
25 into trouble.

1 The baby didn't come in with a Category III. If the baby
2 starts with a Category I, goes to Category II, and then starts
3 approaching or gets to a Category III, that's a baby that
4 you're watching in trouble in front of your eyes.

5 So what do you do? You have to stop the trouble. If
6 you're giving Pitocin, stop it. Give the mother oxygen.
7 Increase her IV fluids. Put her on her side to increase blood
8 flow to the uterus.

9 If you can't resolve the category and delivery is not
10 imminent, then you've got to go to plan B because we want to
11 send a healthy baby home. You have to do a -- that's an
12 indication for a caesarian section.

13 Q. I want to talk a little bit about careful monitoring.

14 Is it possible for the monitor to pick up the baby's
15 heart rate? That's what it's intended to trace, correct?

16 A. Yes.

17 Q. Sometimes will it skip and instead of recording the
18 baby's heart rate, it can pick up the mother's rate and
19 display that?

20 A. Yes. It's a transducer. It's not perfect and especially
21 in the later stages of labor, when it's hard to pick up the
22 baby, you know, minutes or an hour or so before delivery when
23 the baby is descending into the pelvis, it's hard to pick it
24 up. You know, placement is everything with these transducers.
25 And you could end up placing it over a maternal vessel. And

1 in fact you think you're picking up a fetal heartbeat and
2 you're actually picking up a maternal heartbeat.

3 Q. Good, careful monitoring, if somebody is really paying
4 attention as a healthcare professional managing a labor and
5 delivery, is that something that they would discern, that
6 they're actually picking up a maternal versus a fetal heart
7 rate?

8 A. Yes, you would discern that because, first of all, if all
9 of a sudden there's an acute change, ask yourself why is there
10 an acute change all of a sudden. For the better or worse, why
11 is there an acute change?

12 Really simple thing, take the mother's pulse. Take her
13 pulse and then look at what's going on on the monitor. If
14 they're exactly the same, chances are you're picking up the
15 maternal pulse rather than the fetal pulse. So if the fetal
16 pulse is at 150, and all of a sudden it goes to 120, and the
17 mother's pulse is 120, it's more likely than not.

18 What do you do? If you're not sure, you put in a scalp
19 electrode. We have the technology. We've had it for years.
20 That technology came about in the '70s. We're not talking
21 about state-of-the-art here. Scalp electrodes and pressure
22 transducers have been available since the 1970s. So this
23 isn't like -- this isn't high-tech Google kind of stuff.
24 We're talking about 1970s technology.

25 Q. Talk to me about -- so I contacted you to perform a

1 forensic analysis of what happened in this case; is that
2 correct?

3 A. You did.

4 Q. And what materials have you reviewed prior -- in
5 investigating this case?

6 A. You sent me her records. So I looked at her antepartum
7 records for this particular pregnancy, okay? So I don't have
8 gynecologic records prior to this pregnancy. But to this
9 pregnancy, I looked at the midwifery records, I looked at the
10 hospital records and I looked at various depositions.

11 Q. Okay. Have you looked at the depositions from the two
12 nurses who were involved in the care and treatment of this
13 case?

14 A. I have.

15 Q. And have you reviewed the fetal heart rate tracing from
16 the Bellevue Medical Center?

17 A. I did. That was part of the hospital records.

18 Q. Okay. And have you reviewed the fetal heart rate tracing
19 that was taken on October 31st at The Midwife's Place?

20 A. I did.

21 Q. And have you reviewed the radiological reports that were
22 taken and generated after Sage was born?

23 A. I did.

24 Q. Okay. And have you reviewed the reports of other experts
25 who are opining in this case?

1 A. Yes, I did.

2 Q. And was one of those a report of Patrick Barnes --

3 A. Yes.

4 Q. -- who is a physician at Stanford, he's a pediatric
5 neuroradiologist?

6 A. Yes, sir.

7 Q. Just now generally, walk us through how you go about
8 analyzing this type of case.

9 A. So I've been doing this for -- you know, I told you I've
10 been doing this since the late 1980s. And as an expert, I'm
11 not an advocate in this case. The outcome of this case is of
12 no significance to me.

13 What I do is I sit down and I look at this prospectively,
14 meaning I put myself in the shoes of the healthcare providers
15 as the time goes on. In other words, I don't look at the
16 outcome and then go back and see what they did wrong if they
17 did something wrong. I look at things prospectively.

18 In fairness -- in fairness, I'm not going to misrepresent
19 that I don't know that there was a bad outcome here, okay?
20 Mr. Cullan sends me a case, I know there's a bad outcome. I'm
21 going to be honest with you.

22 However, I'm an expert at this. And as an expert, I
23 don't let that influence my analysis going through this
24 prospectively and seeing if -- would a similar person of
25 training, in a similar or same circumstance, act the way these

1 people acted? Did they conform to the standards of care?
2 That's what I was asked to do.

3 I was asked to take a look at these records and see did
4 people comply with the standards of care when it came to the
5 labor and delivery of this patient.

6 Q. So I guess now would be a good time to start looking at
7 the actual records involved in this case.

8 MR. PATRICK CULLAN: May I move to the ELMO?

9 THE COURT: You may.

10 MR. PATRICK CULLAN: And at this time, I would offer
11 Exhibit 2 into evidence, the chart from The Midwife's Place.

12 MS. CHEATLE: No objection, your Honor.

13 THE COURT: Exhibit 2 is received.

14 BY MR. PATRICK CULLAN:

15 Q. Just tell us, what does the chart contain from The
16 Midwife's Place, the antenatal record.

17 A. So we have the antenatal records. So when people come in
18 for their visit, the mother's blood pressure is checked, her
19 weight is checked, her urine is checked for glucose and
20 protein. The baby's heart rate is listened to. Any tests
21 that are done are in the records such as screening for
22 diabetes or that nature. Conversations are documented.
23 Birthing plans are in the record. Any events that happen,
24 especially near term in terms of phone calls and conversations
25 are all documented in the records.

1 Q. I'm just going to -- the chart's about 80-some pages.

2 I'll start with one of the earlier visits. This is from --

3 MR. PATRICK CULLAN: This is page 8, for the Court.

4 A. Okay.

5 BY MR. PATRICK CULLAN:

6 Q. Just walk us through -- I picked this at random. What is
7 this? What does it show us?

8 A. So you look up on top and you see the date of it --
9 you're all looking at it, right?

10 So you see the -- it's recorded as July 13, 2012, at
11 12:46. And it's subjective. It's talking to the patient.
12 Patient presents at clinic for routine OB visit, 25 weeks.
13 For EDD, which is estimated date of delivery, is October 24.
14 She currently denies any concerns so the objective element is
15 talking to her. She tells the healthcare provider that she's
16 feeling fetal movement. It's a positive sign.

17 Changes since the last visit, client states that her lips
18 are dry. And they talk to the patient, ask, "How have you
19 been doing since the last visit?" Encourages increasing
20 fluids, so...

21 And then objective, it says -- objective is data, it's
22 not about conversation. So what this sheet is saying is go
23 look at the antepartum sheet and you'll see the data.

24 And the assessment, in other words, what the evaluation
25 of the person who saw her was; that it's an intrauterine

1 pregnancy of 25 weeks within normal limits; in other words,
2 it's a normal, ongoing pregnancy. Continuing with the
3 prenatal vitamins. She's told to return in four weeks, which
4 is appropriate.

5 The nurse signs the note, and it's electronically signed
6 by the nurse-midwife Heather Ramsey. It's dated -- I guess
7 she signed it the next day, which is July 14th at 9:24 a.m.

8 Q. Okay. Any concerns at this stage?

9 A. Zero.

10 Q. And if we kind of look at the notes running up to when
11 she was at term, we pretty much can see the same thing. It's
12 assessed to be a normal pregnancy, within normal limits, good
13 fetal movement, reassuring?

14 A. Right. So you can see assessment, normal first
15 pregnancy.

16 MR. PATRICK CULLAN: I'm sorry. I moved -- I'm
17 displaying page 20, your Honor.

18 THE COURT: Thank you.

19 A. You see the date up on top. It's October 22. And bottom
20 line is this patient's doing well by the assessment of the
21 person who is examining her.

22 BY MR. PATRICK CULLAN:

23 Q. Okay. And she's basically coming to term at this point
24 in time, correct?

25 A. You're correct, yes. Her due date is three days from

1 this exam.

2 Q. I want to move to the next date.

3 MR. PATRICK CULLAN: Page 22, your Honor.

4 BY MR. PATRICK CULLAN:

5 Q. October 29, 2012. What's the situation here in terms of
6 where we're at in the pregnancy?

7 A. So she's past her due date. You can see the date of the
8 exam is October 29; the due date is the 25th. She's four days
9 past her due date.

10 Q. Okay. I can zoom in a little.

11 What's the significance of that?

12 A. Well, 90 percent of people deliver plus or minus seven
13 days of their due dates. So the four days are not --

14 Q. So when you move past that, that becomes --

15 A. Then you're an outlier. You're in the 10 percent group
16 as soon as you go beyond 41 weeks.

17 Q. Okay. Any concerns at this stage with anything?

18 A. No. According to the assessment here, we have a normal
19 first pregnancy.

20 Q. Good fetal movement, no concerns, no complaints?

21 A. Right.

22 Q. Okay. And she's taking an early discharge class. She
23 signed up for that?

24 A. Yes.

25 Q. And there's mention of some of the other types of

1 classes. She took a Lamaze-type class called Hypnobabies.
2 That's mentioned in the records.

3 A. Sure.

4 Q. Anything unusual with what we see when you go through
5 this?

6 A. I don't see anything unusual.

7 Q. Okay. Now I'll turn to the 31st record, this is page 24.

8 A. Okay.

9 Q. Tell us what's the -- just read through what's happening
10 here and tell us what's important in terms of your assessment
11 of what's happening.

12 A. Okay. Now we have a whole different history here. We
13 have a patient that's been saying that she's been contracting
14 for over a day, the 24-plus hours; that she's had little
15 sleep. She's 41 weeks. She's seven days past her due date.
16 Remember I told you statistically 90 percent of people go
17 within plus or minus seven days of their due date. Here she
18 is seven days, complaining of regular uterine contractions.

19 She's examined. And lo and behold, she's 2 to 3
20 centimeters dilated, she's 90 percent effaced, minus three
21 station, cephalic meaning that the head is down and posterior.

22 Q. Okay.

23 THE COURT: Mr. Cullan, let's go ahead and continue
24 for another ten minutes. I can give you another ten minutes
25 this morning.

1 MR. PATRICK CULLAN: Thank you, your Honor.

2 BY MR. PATRICK CULLAN:

3 Q. From a standpoint of starting to weigh into the -- kind
4 of the risk analysis of a labor like this, what are we looking
5 at?

6 A. Low risk.

7 Q. Why?

8 A. You have a healthy young woman who has no medical
9 problems, who is now 41 weeks, comes in complaining of a day's
10 worth of contractions, and she's dilating, which is great.
11 She's 2 to 3 centimeters, 90 percent, which is actually
12 terrific.

13 The minus three is not a red flag, it's a yellow flag. I
14 wish she was at zero station. Most first-time mothers would
15 be at a zero station. So there's a little bit of concern
16 about the fitting of the baby.

17 But at this point, I would tell her I have a small
18 concern about that minus three station; but otherwise, my
19 diagnosis of this -- on this day is that she's in the early
20 stages of labor, what we call the latent phase of labor.

21 Q. Okay. We mentioned effacement and what that is. Tell us
22 about the percentage. She's 90 percent effaced. Tell us what
23 that is.

24 A. That's very significant. Most first-time mothers, they
25 dilate a lot before they efface a lot. And so they get to 4

1 or 5 or 6 centimeters, and still 40, 50, 60 percent. The hard
2 work in laboring, the painful work, is the effacement, not the
3 dilating.

4 That generally takes longer -- that's like a latent phase
5 of labor, can be up to 20, 24 hours in a first-time mother.
6 They're not dilating much, but they're effacing.

7 So the fact that she's 90 percent and have to get to a
8 hundred, that's really terrific. I must tell you, I don't see
9 too many first-time mothers presenting 90 percent effaced when
10 they first present in the early phases of labor. This is
11 terrific.

12 Q. I want to in detail go through the objective section of
13 this. We heard in opening statement that there's going to be
14 representations that Sage's brain was eaten away two to three
15 days before she ever arrived at the Bellevue Medical Center.
16 Okay? I'm going to represent that was said to the jury.

17 Now I want you to walk through the objective findings --
18 and explain again what objective means.

19 A. Objective is what you're -- objective is what -- it's the
20 factual information. Subjective is a conversation; objective
21 is the data you're collecting.

22 Q. So walk us through the objective evidence that's
23 available to us from this day. And tell us how it relates to
24 whether or not this child's brain has been eating -- has been
25 eaten away or is being eaten away at this time.

1 A. So the most important --

2 MR. WELCH: Let me interpose an objection, no proper
3 and sufficient foundation for this witness. He's an expert in
4 obstetrics, not in neonatology, not in neurology. So it's
5 asking for a counter opinion, and I don't believe he's
6 qualified under Rule 702. And it wasn't disclosed.

7 THE COURT: That can be addressed on cross.
8 Overruled.

9 A. So if you look at the second sentence on the first line:
10 "See NST which is reactive."

11 So what that means, they put a belt on with a kind of
12 external monitor we talked about, and they evaluated the
13 baby's heartbeat. And reactive is the best you can do. That
14 means there are good accelerations.

15 I can tell you statistically that 999 out of 1,000 babies
16 are healthy, well babies when the NST is reactive. It's a
17 very reassuring sign. It's what we call an antepartum
18 evaluation. It's not an in-labor evaluation. But when we see
19 these accelerations which defines what a reactive nonstress
20 test is, it's extremely reassuring.

21 BY MR. PATRICK CULLAN:

22 Q. We'll look at that in a minute. But anything else from
23 the objective assessment to even suggest any evidence of a
24 brain being eaten away?

25 A. No. With all due --

1 MR. WELCH: Your Honor, again I have to interpose the
2 same objection, no proper and sufficient foundation; also
3 outside of the Rule 26 report.

4 THE COURT: Well, overruled. He may answer.

5 A. I would say based on the reactive nonstress test, with
6 all due respect, that's a ridiculous statement to suggest the
7 baby's brain is being eaten away. To a 99.9 percent
8 probability, you have an intact central nervous system with a
9 reactive nonstress test.

10 BY MR. PATRICK CULLAN:

11 Q. Why is a nonstress test done?

12 A. Because she's not going to go to the hospital and she's
13 not going to stay at the birthing center. So this is a
14 patient that wants to do things as naturally as possible.

15 So before you send the patient home -- because she is
16 laboring, she's 2 to 3 centimeters, she's 90 percent, she's
17 reporting contractions, she hasn't slept well in over 24
18 hours.

19 Before you send her home, here's the term again, you want
20 to do no harm. You want to make sure that the baby's okay.
21 And the best way to make sure the baby is okay is to do a
22 nonstress test. It's a very good thing they did the nonstress
23 test. But we know, there's great clinical data, that when the
24 test is reactive, the baby, to approaching 100 percent
25 probability, greater than 99 percent probability, is fine and

1 neurologically intact.

2 Q. So the whole purpose of the nonstress test is to make
3 sure that Sage is doing well before they send her home.

4 A. Absolutely.

5 Q. Now, in the records -- this will be page 26, 27, and 28.
6 And I'll just lay the -- 26 up, and it's sideways --

7 A. Uh-huh.

8 Q. -- as it was printed. And this is how these medical
9 records were provided to us during litigation.

10 A. Okay.

11 Q. Take a moment and explain what it is we're looking at
12 here. And I think you can use the screen to make --

13 A. Sure. So what you're looking at is a classic reactive
14 nonstress test. Can I use my finger on this? Oh, great.

15 So here, you see these -- this is an acceleration. This
16 is an acceleration. This is an acceleration.

17 So you have nice variability that you all see. It
18 doesn't look like somebody took a ruler and went across the
19 screen there. You see those ups and downs, the variabilities
20 in contractions. They look beautiful.

21 And you see, you know, these -- here's a contraction
22 here. So she's contracting; she's not contracting a lot. And
23 this is just a beautiful reactive tracing. And I would have
24 sent her home as well.

25 Q. Okay. And it goes on. They recorded Sage about a half

1 an hour --

2 THE COURT: To remove the marks, I believe you touch
3 on the lower right side --

4 MR. PATRICK CULLAN: I just did.

5 THE COURT: Very good. Thank you.

6 A. So if you look here, this is sort -- that's sort of a
7 baseline, okay? And you see these beautiful accelerations
8 here and here and here. It's just another contraction here.
9 This is a contraction pattern not occurring too frequently.
10 So what you're seeing is somebody who is contracting, no
11 question about it, a beautiful reactive tracing.

12 BY MR. PATRICK CULLAN:

13 Q. I want to point one thing out.

14 MR. PATRICK CULLAN: I would offer Exhibit 3 at this
15 time. And this is the fetal heart rate tracing from the
16 Bellevue Medical Center.

17 THE COURT: Exhibit 3 is already in evidence from the
18 pretrial conference.

19 MR. PATRICK CULLAN: Okay.

20 BY MR. PATRICK CULLAN:

21 Q. Now, this strip that's been photocopied and provided to
22 us is actually what it would look like if it's coming out of a
23 machine, correct?

24 A. Yes.

25 Q. The dimensions, the time scale, correct?

1 A. Yes.

2 Q. And that's completely different -- I just want to clarify
3 this. We're going to be looking at this later.

4 THE COURT: And what is that exhibit?

5 MR. PATRICK CULLAN: Exhibit 3, page 1.

6 THE COURT: Thank you.

7 BY MR. PATRICK CULLAN:

8 Q. And just -- tell us the difference between the two
9 monitors strips, the one we're looking at from Bellevue that
10 we're going to look at here in a minute and the one from The
11 Midwife's Place.

12 A. Well, you can see it's a different -- it's on a different
13 pattern, okay? It's just -- it's not the same. That if you
14 look here, these dark -- there's -- these lines are one-minute
15 lines. You don't see -- these tiny little boxes are ten
16 seconds, so you don't get to see that so well down below.

17 So the grid is -- the grid appears differently.

18 Q. So they're different scales completely?

19 A. Yeah, they're different grids.

20 Q. But the principles are identical.

21 A. Yes.

22 Q. So I just want to follow up. This is page 2 of the
23 nonstress test, page 27 of the exhibit, and again during this
24 time frame, anything other than an absolutely health baby
25 represented here?

1 A. No. I would call this tracing reactive, just as they do.
2 And reactive tracing means to the highest statistical
3 probability that you're dealing with a well baby.

4 Q. What would you say if somebody came in and represented
5 that this is not reactive, that this is bad?

6 A. If someone called this nonreactive, I would challenge
7 them.

8 Q. Correct. Is there any object -- we saw contemporaneously
9 -- before any lawsuit, it was called reactive. Would there be
10 any reason now to try and represent this as anything else?

11 A. No. What was stated in the records is correct. It's a
12 reactive nonstress test. We're all looking at the
13 accelerations here. They're beautiful. A reactive nonstress
14 test is defined as two -- as two accelerations in a 20-minute
15 window that are 15 beats lasting 15 seconds above the
16 baseline. And right here you see it. Here's one and here's
17 one right here.

18 Q. And that's nowhere near 20 minutes. This is, I think --
19 I think these are six-minute panels.

20 A. No, this is just a nice reactive tracing.

21 Q. And then finally the last page of that tracing...

22 A. Here you see another contraction down here. You see
23 another acceleration right there.

24 So it's a pattern that if the patient was not ready to go
25 to the hospital, I would feel most comfortable sending her

1 home.

2 THE COURT: Mr. Cullan, it is now 11:40. So we will
3 recess until two o'clock. Please come back and assemble in
4 the jury deliberation room before two o'clock, and we will
5 resume at that time.

6 Thank you. We are in recess.

7 (Jury out and recess taken at 11:41 a.m.)

8 (At 2:06 p.m. on July 28, 2015, with counsel for the
9 parties, plaintiff Doran Schmidt, and the defendant's
10 representative present, and the jury NOT present, the
11 following proceedings were had:)

12 THE COURT: Do we need to discuss anything before the
13 jury comes in?

14 MR. WELCH: No, your Honor.

15 MR. PATRICK CULLAN: No, your Honor.

16 THE COURT: All right. Please bring in the jury.

17 MARTIN GUBERNICK, PREVIOUSLY SWORN, RESUMED THE STAND

18 (Jury in at 2:06 p.m.)

19 THE COURT: Please be seated.

20 Mr. Cullan, you may continue with your direct
21 examination.

22 MR. PATRICK CULLAN: Thank you.

23 DIRECT EXAMINATION

24 BY MR. PATRICK CULLAN:

25 Q. Dr. Gubernick, I know you have a flight to catch. We're

1 going to try and expedite getting through yours so defense
2 counsel has time to ask you questions as well.

3 A. Thank you.

4 Q. We left off with -- on October 31st, they had done the
5 assessment and sent Doran home. And she went into the
6 Bellevue Medical Center the next morning?

7 A. Yes.

8 Q. I just want to go through those records quickly so that
9 we've seen them and know how to interpret them.

10 So this is the record. And tell me if I'm not correct,
11 the times of various events are labeled here on the side.

12 A. Yes, they are.

13 Q. And then vital signs are recorded for Mom, for Doran, in
14 the second column.

15 A. Yes, they are.

16 Q. The third column is the fetal heart rate, how Sage is.

17 A. You're correct.

18 Q. And then contraction information.

19 A. Yes.

20 Q. And assessments.

21 A. Yes.

22 Q. Now, I just want to focus in on a few assessments.

23 First of all, they're very hard to read, but at any time
24 was there any concern on anyone's behalf as to Sage?

25 A. No.

1 Q. And if we go to 7 -- sorry, 5 a.m., did they do the first
2 vaginal exam?

3 A. Yes. She came in at approximately one o'clock in the
4 morning. First vaginal exam was done at 5.

5 Q. And she was 7 --

6 A. She was 7 centimeters, 100 percent effaced, and minus one
7 station.

8 Q. So 100 percent effaced, is there anything left to do in
9 terms of effacement?

10 A. No.

11 Q. Okay. And the minus one station, what does that mean?

12 A. The head's getting close to being engaged but not engaged
13 yet.

14 Q. Okay. Still not engaged?

15 A. Right.

16 Q. And then if we turn now -- this is just -- I just want to
17 briefly mention this. At 8:35 it's recorded that she had an
18 SROM. What's that?

19 A. Spontaneous rupture of membranes.

20 Q. And what's it state after that?

21 A. "Clear fluid."

22 Q. And what's the significance of that?

23 A. Well, amniotic fluid is normally clear. If the baby is
24 under any kind of stress in utero, they have a bowel movement
25 in utero. And we call that meconium.

1 So we like to see clear fluid because that means the
2 environment inside is a healthy environment and the baby
3 hasn't been stressed by any sort of thing.

4 Q. What's the risk now that the rupture -- the membranes
5 have ruptured?

6 A. So the baby is in this environment, this balloon, called
7 amniotic fluid, amnion. And as soon as the membranes are
8 ruptured, the clock is sort of ticking in terms of the ability
9 for infection to ascend, to go up from the vagina, where
10 there's normal bacteria, into the cervix, into the uterine
11 cavity now that it's open because the membranes are ruptured.

12 So the clock is ticking in terms of the risk of
13 infection.

14 Q. And then if we move down, at ten o'clock they check her
15 again and she's still at 7. And the plan is then to do what?

16 A. At ten o'clock, they're going to recheck her one more
17 time, I think, in the future. And if her exam does not
18 change, she's going to be transferred to the hospital where
19 she's going to receive IV Pitocin.

20 Q. Sorry, I was off on the thing. It's "transfer to
21 hospital," correct?

22 A. Right. She's examined at ten. I think you missed one
23 more exam at 11. And then the decision is made to transfer to
24 the hospital about 11:20. And she gets to the hospital
25 approximately noontime.

1 Q. Okay. Now I just want to turn to the hospital.

2 MR. PATRICK CULLAN: This is Exhibit 3, page 1 for
3 the Court.

4 BY MR. PATRICK CULLAN:

5 Q. And this is the fetal tracing that the hospital provided
6 in litigation, correct?

7 A. Yes.

8 Q. And there's approximately 18 -- each one of these boxes
9 is one minute. Is that true?

10 A. Yes, you're correct.

11 Q. As we're looking here through this first almost hour of
12 tracing, is that evidence of adequate uterine activity?

13 A. It looks that way, sure.

14 In other words, this is an external system, okay? So we
15 don't know the amplitude of the contractions. But certainly
16 the frequency of the contractions are very good.

17 Q. Okay. And there's adequate rest?

18 A. Yes. There's good rest. Yeah, sure.

19 Q. Okay. And how is Sage doing in terms of her heart rate?

20 A. Great.

21 Q. Okay. And then --

22 A. Good accelerations, good beat-to-beat variability, no
23 decelerations. So this is a reassuring tracing, a Category I
24 tracing.

25 Q. And the nurses -- this is just kind of -- this is

1 Exhibit 4. The nurses, when they were deposed, had to mark up
2 the tracings. And they circled the contractions. And they
3 noted if it's a Category I tracing or if it's a Category II.
4 And everybody agrees that Sage comes in at a Category I,
5 correct?

6 A. Yes.

7 Q. Just going back to the clean copy, if there's adequate
8 uterine tracing evidenced by the external monitor, is there
9 any indication to start Pitocin?

10 A. No, because if -- again, it gets back to those Ps we
11 talked about. If the power looks good, if she's contracting
12 well, there's good resting tone in between the contractions,
13 and power is not the issue, there's absolutely no indication
14 for Pitocin.

15 Q. Okay. They start the Pitocin and just -- here's the next
16 kind of hour of strip. What has changed?

17 A. It looks like a whole -- you know, it's a whole different
18 pattern. I mean, just take a look at that. See how more
19 frequent the uterine contractions are, how there seems to be
20 less resting -- especially if you go down to the bottom.

21 Do I have a finger here? Yeah, I can do it.

22 Q. Oh, sorry.

23 A. If you look over here and you look over here, you're
24 starting to see the contractions are not coming down to
25 baseline before the next contraction starts. So this is a

1 whole new ball game.

2 And if you look over here --

3 Q. Sorry.

4 A. If you look over here, these two little couplings that
5 you have here...

6 Q. Okay.

7 A. So all of a sudden, you start the Pitocin. Obviously the
8 person's sensitive to the Pitocin. They started two
9 milliunits. And the contraction pattern looks totally
10 different.

11 Q. Okay. The contraction pattern, let's just walk through
12 that. These types of things that are appearing with the heart
13 that we start to see more frequently --

14 A. Right. Those are called variable decelerations. And by
15 definition, once you start seeing those, that's a Category II
16 tracing.

17 Q. Okay. And you mentioned just -- for instance, does this
18 contraction return to baseline --

19 A. No.

20 Q. -- before the start of another?

21 A. No. You see this here? You see this here? There's no
22 return back to baseline.

23 Q. So if we look and contrast that to the first
24 monitoring -- I'm going to put up page one underneath page two
25 so we can see the first tracing, how are the contractions

1 different?

2 A. Day and night. Just look at it. Before the contractions
3 go down to a zero baseline. There's good resting time in
4 between the contractions. She's having adequate contractions,
5 three contractions in ten minutes is adequate contractions.

6 And all of a sudden, you're seeing the contractions
7 getting bunched together. They're coming more frequent.
8 They're coming on top of each other. And there isn't full
9 relaxation of the uterus before the start of the next
10 contraction with some of these contractions.

11 Q. Okay. The heart rate category here is a what?

12 A. It's a II.

13 Q. Okay. And the medical science and safety principles
14 applicable to heart rate monitoring, if you get a Category II
15 and you're on Pitocin, what should happen?

16 A. You should turn down or turn off the Pitocin because you
17 want to move it back to a Category I.

18 Q. Okay. At this point in time, how much is the load?

19 A. Load?

20 Q. Two milliunits?

21 A. She's getting two milliunits.

22 Q. So can you turn that down or do you have to turn it off?

23 A. You have to turn it off.

24 Q. Okay.

25 MR. PATRICK CULLAN: Your Honor, at this time, just

1 to kind of go through some highlights, the doctor prepared a
2 summary of events. I'd like to use this as a demonstrative
3 aid. Would that be appropriate?

4 MR. WELCH: My only objection is, Judge, it's never
5 been provided to us, so I can't verify what's on there is
6 accurate or not.

7 If the witness wants to refer to it, that's fine. But I
8 haven't checked the accuracy of it so I don't think it should
9 be published to the jury.

10 THE COURT: All right. Unless you want to take the
11 time to give defense counsel a copy and have defense counsel
12 review it and then register any objection --

13 MR. PATRICK CULLAN: I'll hand it to you.

14 MR. WELCH: I don't have time to sit there and match
15 up the times with the records.

16 THE COURT: All right.

17 MR. PATRICK CULLAN: That's okay, your Honor.

18 THE COURT: Objection sustained.

19 MR. PATRICK CULLAN: Okay.

20 BY MR. PATRICK CULLAN:

21 Q. I just want to walk through a couple more pages.

22 The actual strip itself is, I think, 19 pages -- or 17
23 pages?

24 A. Yes.

25 Q. And so this is just hour after hour after hour of

1 recordings, correct?

2 A. Yes.

3 Q. Does the fetal heart rate ever return to a Category I?

4 A. No.

5 Q. Does the uterine activity ever not -- is it -- are there
6 times when it's actually not excessive?

7 A. In the course of the entire labor here, we may find a
8 small window where the contractions have spread out. But we
9 look at the overall pattern. And the overall pattern here is
10 a tachysystole, poor resting in between contractions, periodic
11 coupling meaning contractions one on top of each other, and
12 periodic tetanic contractions which are contractions that last
13 too long.

14 So over all, it's a contraction pattern that we don't
15 like to see because it's concerning that the baby's oxygen --
16 that the oxygen flow to the baby can be compromised.

17 Q. Okay. Now it's in here -- the Pitocin was just started.
18 Is it in here, according to the medical records, that the
19 patient starts to complain of significant pain and requesting
20 epidural intervention?

21 A. Yes.

22 Q. Okay. Just walk us through what the monitor is picking
23 up here, if anything.

24 A. I would say that's a loss of information. There's a
25 classic example of where the baby could be moving, the mom

1 could be moving, whatever. And we're missing information, and
2 that's always concerning when you're using a drug like Pitocin
3 to not be seeing what's going on.

4 Q. Okay. Now at some point in here, she is getting an
5 epidural; is that correct?

6 A. Yes, approximately, I think, about 4:15.

7 Q. Okay. But she's not getting an epidural for 30, 40
8 minutes, is she?

9 A. 30, 40 minutes from this time?

10 Q. Throughout that time.

11 A. Yes, that's correct.

12 Q. So if the nurse -- and I think the records will reflect
13 someone's charting the uterine frequency, the duration, and
14 the strength of the contractions. Certainly they're not
15 gleaning this information from what we're looking at right
16 here on page 3 of the tracing, correct?

17 A. Not from here, they're not.

18 Q. So if they're remote monitoring at the desk, there's just
19 no way you can document anything with respect to contractions,
20 true?

21 MR. WELCH: Objection, leading and suggestive.

22 THE COURT: Please rephrase.

23 MR. PATRICK CULLAN: Sure.

24 BY MR. PATRICK CULLAN:

25 Q. Can a nurse at a nursing station, for instance, on this

1 last strip -- this is 20 minutes -- tell anything about the
2 contractions?

3 A. She can't tell anything; I can't tell anything.

4 Q. You'd have to -- what would you have to do to get any
5 information?

6 A. You have to either readjust the Toco or put in an
7 internal pressure catheter.

8 Q. Okay. And again is there any return to baseline with any
9 of the contractions here on page 4?

10 A. No. No.

11 Q. Potentially good rest here? I mean, that's over a
12 minute, correct?

13 A. That looks okay.

14 Q. Okay. And then we have some contractions here where we
15 don't, but what's happening here with respect to the
16 contractions?

17 A. I think they're just coming -- I mean, again we're all
18 looking at this. They're just coming one on top of the other.

19 Q. But we're getting --

20 A. And instead of getting that nice little flat area in
21 between the contractions, you're starting to get that loopy
22 look because it never really comes down and stays down. In
23 other words, as it's starting to come down, it's getting ready
24 to go up again. So it starts to get that loopy look of
25 contraction after contraction.

1 Q. But this is over a minute of contractions. So is that --
2 doesn't that make everything okay?

3 A. This is not okay. This is a tachysystole. There's too
4 many contractions, not enough rest between the contractions.

5 And what's evident here is that we're starting to see --
6 we're starting to see decelerations, albeit at this point
7 relatively minor, but decelerations that a reasonable
8 healthcare provider would conclude is secondary to the
9 tachysystole that they've created with the Pitocin.

10 Q. Did Sage demonstrate in that first hour of tracings any
11 of these types of decelerations or anything?

12 A. No.

13 Q. Just turning again, you know, we have times where Sage is
14 getting good rest, correct?

15 A. Right. That's what I said. It's not continuous. There
16 are some contractions with the arrest. But then, I mean, look
17 down at the bottom there. Look what's happening at the bottom
18 right. I mean, you're not getting any rest there. The
19 contractions are coming one on top of the other.

20 Start to look up on top. Remember when I talked about
21 the straight line? It's not looking as variable as it used to
22 look. I'm not saying that is a straight line, that's not
23 absent variability.

24 But look here. That doesn't look like what we saw
25 before. That's starting to get kind of straight. And that's

1 a reflection of oxygen delivery to the baby. And no surprise
2 when you start doing this (indicating), you're going to start
3 getting this (indicating). Okay?

4 So that's what we're seeing. So what needs to happen
5 here? Pitocin needs to be shut off.

6 Q. I'm going to just keep kind of cruising through this.

7 We see more of the same. Are these couplets you called
8 them?

9 A. I would actually argue it's not more of the same, it's
10 starting to look a little worse. Because that's starting to
11 look a little flat. That's almost looking like you're using a
12 ruler. That clearly is looking like you're using a ruler.

13 Look at this over here. And you have these
14 decelerations. So it's not more of the same, it's worse.

15 And there's another deceleration. And there's some
16 coupling.

17 And look at this, look what's going on here. I mean,
18 this is not an okay labor pattern. And this is a labor
19 pattern that -- again, I'm going to use that word iatrogenic.
20 This is being induced by them giving Pitocin, and they've got
21 to stop the Pitocin.

22 Q. Okay. Any rest between these three contractions here?

23 A. No rest here. More decelerations here. More flattening
24 up here. Look at the runs of contractions here. Look what
25 this looks like down here.

1 So what's happening is the contractions -- we've gone
2 through this a good part of the day today. The contractions
3 are coming one on top of the other, the muscle's contracting
4 too frequently, the blood flow through the muscle's getting
5 depressed, the oxygen delivery to the baby is getting
6 depressed, and you're seeing what's happening.

7 Q. And this is -- okay. This is seven o'clock. This is the
8 shift change.

9 A. Yes.

10 Q. Okay. And this deceleration here is when the nurse left
11 and made some notations in the chart. Do you recall that?

12 A. Yes.

13 Q. Okay. And what was the significance to the nursing
14 staff? She documented a prolonged deceleration. What's the
15 significance of --

16 A. There's an audible prolonged deceleration. Baby's heart
17 rate went down below 15 beats between two and ten minutes.
18 And the Pitocin -- I believe it was at that point that the
19 Pitocin was turned off. So somewhere around here, the Pitocin
20 is being turned off. I can't read that print there on screen.

21 Q. Yeah, the print's small.

22 A. But somewhere around 7:20 --

23 Q. Oxytocin off --

24 A. -- so that --

25 THE COURT: Wait, wait. We can't have two people

1 talking at the same time.

2 A. I think that says "Pitocin off". Yeah, there we go.

3 Here. "Pitocin off," which is great. Turn off the Pitocin.

4 And that's the response what they're seeing to what I would
5 call a nonreassuring heart rate pattern.

6 BY MR. PATRICK CULLAN:

7 Q. Okay. Now it was essentially -- if someone comes in and
8 represents that the Pitocin was being turned off so Mom could
9 rest, is that a valid...

10 A. First of all, she's got an epidural in there for three
11 hours. So she can rest? I don't know what that means.

12 Q. Okay. So the Pitocin is turned off. And then oxygen by
13 -- and then it's interrupted because of the way that the thing
14 prints -- but according to the medical records, from here on
15 out, Mom is wearing an oxygen mask, according to the records,
16 true?

17 A. Yes.

18 Q. What's the purpose of the oxygen mask? What are they
19 concerned about?

20 A. Well, what they're concerned about -- they're not
21 concerned about the mother's oxygen status, they're concerned
22 about the baby's.

23 So it's a general resuscitative measure that if the blood
24 supply to the baby is being diminished, you want to maximize
25 the amount of oxygen in that blood to get the most oxygen you

1 can get to the baby. So you put 100 percent oxygen on the
2 mother.

3 Q. The medical records reflect that -- we haven't seen with
4 these medical records, but it's at this time that Heather
5 Ramsey was paged, correct?

6 A. Yes.

7 Q. Okay. And was a vaginal exam done -- I don't know if
8 it's reflected here. Let's just stop here and look at the
9 tracing.

10 A. Yeah.

11 Q. Is this good information about what's happening to Sage's
12 heart in this time frame?

13 A. No. There's too much missing information. This
14 patient -- they need a scalp electrode to be put on the baby,
15 especially with what we're seeing has been going on.

16 Q. Okay. That's recovery notes.

17 Just so we can introduce the -- a little bit about the
18 medical records here, these are the Bellevue records that
19 correspond with this time frame. And I just want to point out
20 how these are set up. So there are times that run across and
21 then there are columns. And underneath the times are charted
22 what's taking place at those various time periods, correct?

23 A. Yes.

24 Q. And the categories of what is being charted is here?

25 A. Yes.

1 Q. And so, for instance, they typically chart if there's an
2 exam, who the examiner is, the vital sign for the mom, the
3 baby's heart rate, the uterine activity. And that's kind of
4 what's discussed throughout.

5 A. Yes.

6 Q. Correct?

7 A. Uh-huh.

8 Q. And so if we look at this, the heart rate is continually
9 being described as a Category II, correct?

10 A. Yes.

11 Q. I don't know if that blows up. So they're documenting
12 what they think the category is.

13 A. Yes. This is -- I didn't see it on the left, what time
14 you're talking about. But yes, shortly after the start of
15 Pitocin, they're almost continuously -- almost continuously
16 reporting a Category II tracing.

17 Q. Okay. And at this time, the Pitocin is off -- turned
18 off, it is?

19 A. Yes, I believe it was turned off around 7:20 or so.

20 Q. 1921?

21 A. There you go.

22 Q. Sorry.

23 A. 7:21.

24 Q. And just prior to that, they had paged Heather Ramsey,
25 correct?

1 A. Yes.

2 Q. So Heather is not there actively participating in this,
3 correct?

4 A. Right.

5 Q. This kind of splits to the next page, but they reported a
6 deceleration for five minutes. What does that mean?

7 A. That, by definition, is a prolonged deceleration; greater
8 than two minutes, less than ten minutes.

9 Q. So many Sage's heart dropped out of the normal range for
10 five minutes, correct?

11 A. Yes.

12 Q. And if you actually look at the tracing, did it continue
13 for longer than five minutes?

14 A. I think so, yes.

15 Q. But then you lose the actual heartbeat.

16 A. Then we lose some information, correct.

17 Q. So we see her heart was going along, and then it dropped.
18 And it dropped through the rest of this page. And then at the
19 beginning of the other side of the page, it's just
20 indistinguishable activity, correct?

21 A. Yeah. You can't see on the monitor. I mean, you get
22 some inkling of what's going on. They can hear it on the
23 monitor sometimes, so they're describing it being five
24 minutes. It looks a lot longer than five minutes though.

25 Q. At this time, the records reflect also that an IV bolus

1 was given. What's that for?

2 A. Well, what you want to do is you want to increase blood
3 flow to the baby. This is all about delivery of oxygen to the
4 baby.

5 One of the ways to do it, put a mask on, give her more
6 oxygen. Another way to do it is to fill up her vascular
7 system with fluid so that the heart's, you know, pumping as
8 much fluid as possible. So you give a lot of fluid, what we
9 call an IV bolus, to get the heart moving lots of fluid, lots
10 of blood, to the placenta.

11 Q. Okay. And just quickly again, not much rest -- I think
12 we did this one actually.

13 A. Right.

14 Q. But in fairness, at times potentially that's over the
15 60-second rule -- I mean the 60-second standard.

16 MR. PATRICK CULLAN: Sorry. I'll withdraw that
17 question.

18 BY MR. PATRICK CULLAN:

19 Q. Turning to the next chart, just walk us through what you
20 see here.

21 A. So here's an example -- and they've turned the Pitocin
22 off. And I would have anticipated prospectively that the
23 contractions would slow down.

24 But what happens with some people, even though I told you
25 the half-life of Pitocin is a minute and a half, you get this

1 muscle memory. Once you get the muscle contracting, it just
2 doesn't stop. It's gotten used to contracting every minute,
3 minute and a half. I wouldn't have -- prospectively I
4 wouldn't have anticipated this. But look, she's still over --
5 she's overcontracting here, even off the Pitocin now. And the
6 baby has variable decelerations. We just finished a prolonged
7 deceleration.

8 This woman was stuck at 7 centimeters for almost 13
9 hours. And now we're getting into the 14-, 15-hour range.
10 This has been -- it's my opinion that this has been going on
11 way too long and this baby is in harm's way.

12 Q. Okay. So if we continue now just to the next page, what
13 do we see? Sage -- does she have a Category I heart rate
14 tracing?

15 A. No, this is not a Category I. I mean, there are
16 decelerations all over. They're all over the place, the
17 decelerations. So this is anything but a Category I.

18 And you've got -- still, even off the Pitocin, you have
19 these tetanic contractions. That happens occasionally from
20 muscle memory. Once you get the uterus started with an agent
21 like Pitocin, even when you pull back on the Pitocin, you're
22 still going to get the hyperstimulation.

23 Q. What is a tocolytic?

24 A. So we have agents that we use -- it's just the opposite.
25 First, you're giving Pitocin to increase the contractions.

1 Then we have these agents that we use to slow down the
2 contractions. And we have those and those weren't used here.
3 But these contractions are coming too frequently now.

4 Q. Is this adequate monitoring of her heart, page 9?

5 A. No. I don't believe -- I don't like the fact that we're
6 missing information. We're missing information.

7 Again, if you had a beautiful tracing up here and then
8 you just occasionally lost some information, I wouldn't get
9 too excited over a minute or two of missed information.

10 But this tracing, you're looking at a tracing that if
11 it's going to go on, it's going to go no place but bad. The
12 contractions are happening too often; the baby's responding to
13 these too often contractions with more and more decelerations;
14 we have intermittent diminished beat-to-beat variability -- as
15 I show you now, the variability is back, it was diminished
16 before. And if this is allowed to go on, a reasonable
17 healthcare provider will anticipate that this baby is going to
18 get into trouble.

19 Q. Okay. And I think the records will reflect the nurse is
20 actually denoting that she's losing the heart information
21 during the contractions. Didn't she record that?

22 A. Yes.

23 Q. If she's -- what is required of a healthcare
24 professional, a labor and delivery nurse, who knows -- she's
25 even documenting that she's losing the information during the

1 contractions?

2 A. We're all -- we're advocates for the baby. What do you
3 have to do if you're losing information? This is 2012. Put a
4 scalp electrode on. Easy. It takes literally about ten
5 seconds to put a scalp electrode on.

6 Q. And that's what we talked about earlier?

7 A. Yes.

8 Q. And here -- more of the same?

9 A. More of the same. More of the same.

10 Q. Now what are these big changes in --

11 A. These are decelerations. And these are certain kind of
12 decelerations that we call late decelerations. This is an
13 example of poor perfusion through the placenta. And we got
14 lots more decelerations we're starting to see again. You all
15 see this. We're starting to see the diminished beat-to-beat
16 variability here again, here and here.

17 I'm worried that even when it looks okay here, this could
18 just be artifact because it's an external system. With an
19 external system, they get noise. It sometimes looks like
20 normal beat-to-beat variability when, in fact, it's
21 diminished. That's why she needs a scalp electrode. Because
22 in lots of areas, you're seeing diminished beat-to-beat
23 variability. And you're also seeing lots of little
24 decelerations going on here.

25 And this is a baby in trouble. This is a baby that needs

1 to be rescued.

2 Q. Okay. Now we're at 10:30 here. How would you describe
3 this contraction monitoring?

4 A. I can't interpret that. You know, you see -- remember
5 before how we had the nice hills and we were looking at the
6 hills?

7 Now look at this. What are we seeing? There's missing
8 information here. I can't say for sure. Is this a
9 contraction? It might be. Is this a -- I don't know. You're
10 seeing what I'm seeing.

11 Now we're starting to get, you know, googly-goo here. I
12 don't know what all of this is. I'm concerned about what's
13 going on there. Is there enough arresting tone? How long are
14 there -- are these two contractions here or not, one on top of
15 the other? That would be worrisome.

16 Q. Okay. And just turning now, we're approaching midnight.
17 And I want to focus on a couple things here, just the
18 contraction frequency and the amount of rest between these
19 contractions.

20 A. So one thing I told -- remember I told you they turned
21 the Pitocin off. What we've got to say is that they turned
22 the Pitocin back on.

23 Q. And the time, according to the medical records, that they
24 turned -- first of all, we just went through the time.

25 A. Right.

1 Q. Was it ever a need to turn the Pitocin back on, based on
2 the uterine activity we just saw?

3 A. No. Because we're going to -- we're looking at this
4 screen here. You can see what happened after turning the
5 Pitocin back on.

6 Q. And the records reflect that the Pitocin was turned back
7 on at 9:53, so 2153 --

8 A. Right.

9 Q. -- which is right here.

10 A. Pitocin is turned back on.

11 Q. It's back on.

12 Is this contraction too long?

13 A. Too long, and I think it's probably a couple. It's
14 probably two contractions.

15 And again, you're starting to see that loop-de-loop again
16 that we don't like to see. I mean, look at what's going on
17 here. Big surprise. She was hypersensitive to Pitocin
18 before. They turned off the Pitocin. She was still having
19 excessive uterine contractions. And now they're returning the
20 Pitocin back on.

21 Well, guess what's going to happen in the next few
22 minutes. We're going to see contractions occurring way too
23 often.

24 Q. Okay. Now it's also in this time frame, back when
25 they're turning the Pitocin on, that they're noting that the

1 mother has a fever.

2 A. Yes.

3 Q. Tell us about that and what's significant about that.

4 Quickly, if you can.

5 A. There's something called chorioamnionitis. And if the
6 membranes are ruptured for a long period of time, the placenta
7 can get inflamed, infected. And then if that's allowed to go
8 on, the mother can get infected. And if that's allowed to go
9 on too long, the baby can get infected.

10 So it's a progression from just a normal -- just an
11 inflammation of the chorion, called chorioamnionitis, to an
12 actual infection in the placenta to an infection -- the
13 placenta can actually get infected without the mother or the
14 baby being infected if the delivery happens relatively soon.

15 But if the placenta stays in the mother long enough, the
16 mother can start getting a fever, tachycardia, signs of
17 infection. And if that's allowed to go on without
18 antibiotics for a long enough period of time, then the baby
19 gets infected.

20 Q. Okay. The T38.8C, what's that mean?

21 A. It's a centigrade reading of a fever. That's a fever.

22 Q. On the risk factors that were existing here that this
23 could be a clinical chorioamnionitis were length of labor,
24 length of ruptured membranes, arrest of labor. What else?

25 A. Yeah. If you want to --

1 MR. WELCH: Judge, I'm going to interpose an
2 objection, extremely leading and suggestive.

3 THE COURT: Sustained. Please rephrase.

4 MR. PATRICK CULLAN: I'll withdraw.

5 BY MR. PATRICK CULLAN:

6 Q. We'll move on.

7 Was anything done at any time to treat this presumed
8 infection that now is becoming apparent?

9 A. No.

10 Q. Didn't they order antibiotics at one point?

11 A. Yes. When her fever went up to 38.6 -- and I think that
12 was around midnight, they ordered ampicillin and gent. And
13 the pharmacy stopped it because the patient is penicillin
14 allergic.

15 Q. You've been in many labors and deliveries. Are the
16 patient's allergies stamped on the front of the chart?

17 A. Yes.

18 Q. Is it pretty much all over the chart?

19 A. Yes.

20 Q. If you're a professional labor and delivery room nurse
21 who's taking good active management of a patient, is that
22 something you should know?

23 A. Yes.

24 Q. So why was the drug not given?

25 A. I mean, I can tell you what was said in the deposition.

1 I have no idea why it was not given.

2 Q. Is it the standard of care to order a medication or to
3 send the order to get a medication the patient is documented
4 to have an allergy to?

5 A. You never give a drug to -- that a patient is allergic
6 to, no; especially when there's so many alternatives. You
7 don't have to give penicillin. There are many other drugs
8 that you can give that aren't penicillin that are just as
9 effective.

10 Q. Okay. I want to talk about this strip because what do we
11 see in this particular panel? Because Nurse McLandsborough
12 testified -- and I think she'll testify consistent with her
13 deposition -- that she had no idea what the baseline was of
14 that other than she knew the variability was diminished or
15 absent.

16 What should be happening here under these circumstances?

17 A. An emergency cesarean section, which is just -- this is
18 just a tragedy here. I mean, look at this contraction
19 pattern. Look at this. If I wanted to show somebody classic
20 hyperstimulation, look at this.

21 Q. Is there a minute rest here?

22 A. A minute? I don't know if there's any rest.

23 Q. How about here?

24 A. I don't think there's any rest there.

25 Q. Okay. Now if somebody comes in and says, as a physician

1 practicing here in Omaha, they see this all the time, every
2 day, what would you say about that?

3 A. Don't go to that hospital.

4 Q. Now, this is a Category III, is it not?

5 A. Here it's a Category III. We lost the beat-to-beat
6 variability. And this is an emergency. This is -- this is an
7 absolute -- this is an obstetrical emergency, that -- this is
8 a baby that is on the slippery slope of irreversible brain
9 damage.

10 Q. Now this is midnight here. Sage is born another hour and
11 three minutes later.

12 A. Yeah.

13 Q. Let's turn the page because I want to talk about this
14 section of the strip for a moment. Now we're going from 0016
15 to birth, 0103.

16 A. Right.

17 Q. The nurses documented that this is absent variability.

18 A. This is about as bad as it gets, okay? This is
19 practically what I would almost refer to as preterminal,
20 before death.

21 And then all of a sudden the tracing dramatically
22 improves. But lo and behold, the heart rate is the same as
23 the mother's heart rate. What they're doing here, more likely
24 than that, is they're just picking up the mother's heart rate
25 for a while. They don't know what's going on.

1 Q. I want to focus in on that section, that transition. I'm
2 going to clear the board.

3 Just talk to us about what you're talking about.

4 A. This is a wandering baseline up in somewhere -- I don't
5 even know if we can establish a baseline here, but the baby is
6 somewhere up in the 150s. And you can see it's like we've
7 taken a pen and just drawn a straight line.

8 The autonomic nervous system of this baby is not working,
9 okay? And the beat-to-beat variability is absent. And that
10 is a -- that is a dire sign of a baby losing its neurologic
11 capability.

12 And then if we move to the right, move the sheet to the
13 right --

14 Q. All right.

15 A. -- that just doesn't look like the same baby anymore.
16 And you've got to ask yourself, is there a dramatic
17 improvement here all of a sudden? Why would there be a
18 dramatic improvement?

19 But lo and behold, if you look at what's being monitored,
20 this is the mother's heart rate. This is the heart rate that
21 she has.

22 Q. Okay. Then I want to go down to the end. So for
23 instance, if we just look in here, the mother's heart rate is
24 actually displayed; HR129.

25 A. Yes.

1 Q. And if we go right above that, we see what's recording.
2 And that's basically 129.

3 A. Yes.

4 Q. Now, if you're a professional healthcare provider who's
5 paying good attention to this labor, is that something that
6 should become apparent?

7 A. Apparent. And again, put a scalp electrode on. It
8 happens to all of us that we can get confused at the very end
9 stages of labor. It wasn't their fault that the monitor is
10 picking up baby and sometimes mom. We're not blaming them.
11 But we have the ability to distinguish between the two. You
12 put a scalp electrode on the baby. This way you know you've
13 got the baby, especially when -- oh, I can't go up there.
14 Especially when you know that you had this (indicating). I
15 mean, this is -- this baby's got to come out, you know? And
16 if you see this and you say, well, is that the mother? What
17 happened all of a sudden?

18 Put a scalp electrode on. Takes seconds to do.

19 Q. I want to talk about now a couple things. We talked
20 about this before. What is the science behind a Category I
21 going to a Category III as to when the injury occurred to a
22 baby?

23 A. So that's a classic -- when we look to see when did this
24 all happen; and a classic intrapartum -- during labor -- event
25 is when you watch the tracing go from Category I, Category II

1 to Category III.

2 If the mom comes to the hospital with Category III
3 tracings, you don't know when -- the injury can be difficult
4 to time because it could have been happened before she got to
5 the hospital, while she was in the hospital, did it start out
6 of the hospital and just continue while in the hospital?

7 But when you start out with a beautiful tracing, and then
8 it goes to an indeterminate tracing, and then it goes to a bad
9 tracing, it's pretty obvious what's happening.

10 Q. I just want to talk for a moment about the brain injury.
11 The type of brain injury Sage has, what's the various ways you
12 can get that?

13 A. So there are multiple pathways to get to an ischemic
14 injury -- an irreversible ischemic -- what we call an ischemic
15 encephalopathy; an injury to the brain as a result of oxygen
16 deprivation.

17 And there isn't one avenue to get there, there are many.
18 If it's acute -- and what does acute mean? It's like throwing
19 somebody into a pool with weights and dropping them in the
20 bottom of the pool and drowning them. If it's acute and it
21 happens suddenly, that's one type of an ischemic injury.

22 Another type of ischemic injury is prolonged. In other
23 words, you don't throw the person into the bottom of the
24 swimming pool, you just slowly take away their oxygen over a
25 period of time. And they just slowly get worse and worse.

1 That's what we call a partial prolonged injury.

2 And then is there are traumatic injuries, there are
3 infectious injuries, there are genetic injuries, there are
4 injuries due to diseases that the baby has, like collagen
5 vascular disease that can lead to a stroke in the baby. So
6 there are many ways to end up with an ischemic encephalopathy.

7 Q. Okay. I want to talk about a couple of those.

8 Because defense counsel in opening statement -- and I
9 think we're going to hear a lot about if your pH is above 7,
10 it couldn't have happened during labor.

11 A. Well, that's just not true.

12 Q. Okay. And why?

13 A. Because the -- well, the American College of ObGyn and
14 the American Academy of Pediatrics, they set up a criteria for
15 one of those pathways that I just talked about, an acute
16 asphyxia, throwing somebody in the pool.

17 And they said to meet that -- to really know that you
18 have that, you have to have low pH, bad Apgar scores, multi-
19 system organ failure -- in other words, the liver, kidney,
20 everything falls apart from oxygen deprivation.

21 And you have to have radiologic evidence that you went
22 from a good -- immediately post birth the baby's head looked
23 okay and then a day or two later, it doesn't look okay. So
24 that's a criteria. And that is true for an acute asphyctic
25 event.

1 But that criteria doesn't apply to all the other avenues,
2 all the other alternative pathways to brain damage. It
3 doesn't apply to trauma. It doesn't apply for infection. It
4 doesn't apply for hyperstimulation or tachysystole over a
5 prolonged period of time. It doesn't happen from genetic
6 factors.

7 So that criteria that you heard about applies -- it is
8 true. And it applies to an asphyctic acute injury. That's
9 not what happened in this case.

10 Q. I want to talk about -- so what are the factors that
11 caused Sage's injury?

12 A. This is a multifactorial injury. This is a result of a
13 prolonged hypoxia related to the inappropriate use of Pitocin,
14 which caused tachysystole, and diminished oxygen -- oxygen
15 deprivation over a prolonged period of time.

16 There is an element of chorioamnionitis where this
17 placenta got infected. The mother didn't get infected until
18 the last hour before she delivered. The baby never showed any
19 signs of infection. But if you inspect the placenta -- and
20 the placenta's the heart and lung of the baby. If you impact
21 the placenta with an infection, that can have an impact on the
22 perfusion of the baby.

23 So there's an element of the chorioamnionitis which
24 affected the placenta. There's an element of the hypoxia
25 related to the inappropriate use of Pitocin.

1 And then this baby was stuck for 12 to 13 hours in the
2 pelvis with the uterus contracting without any movement.
3 There's a traumatic element to this, of the head sitting in
4 the pelvis as the uterus contracts, not over two or three
5 hour, not over four hours; over 12 or 13 hours.

6 So this is a multifactorial injury related to trauma,
7 related to infection, and related to hyperstimulation or
8 tachysystole, whatever you want to call it.

9 Q. Doctor, after all of that, I wanted to talk about a
10 couple final things. We heard a lot about chorioamnionitis
11 during opening statement --

12 A. Right.

13 Q. -- and how there's -- and how that caused Sage's injury a
14 couple days before she arrived at Bellevue Medical Center.

15 I want to talk -- just talk to us, if you will, quickly
16 about what is chorioamnionitis, what is histological
17 chorioamnionitis versus clinical?

18 A. So when we send the placenta to pathology, they take
19 slides and they look at the placenta to see if there's any
20 evidence of infection. And if they see infection in the
21 placenta, histologists and pathologists call it
22 chorioamnionitis.

23 Dr. Baergen, who is going to testify, is at my
24 university. I've sent her dozens and dozens -- probably a
25 hundred placentas. I can't tell you how many times she's

1 written "chorioamnionitis" and the baby goes home healthy,
2 mother goes home healthy; no one's ever gotten antibiotics;
3 nobody has an infection; everything is fine.

4 So what she's capable of seeing is histologic
5 chorioamnionitis. You look on a slide. In the placenta
6 there's chorioamnionitis.

7 I know whether the mother gets infected. How do I know?
8 Her heart rate goes up, tachycardia. She gets a fever. She
9 looks sick. I treat her with antibiotics.

10 The pediatricians know if the baby is infected. They get
11 blood cultures, the blood cultures are positive. So in a
12 category of chorioamnionitis, the placenta can get infected,
13 the mother can get infected, and the baby can get infected.
14 It could be all of those, one of those, two of those.

15 In this case, the placenta got infected. The mother got
16 a low grade infection about an hour before delivery. There's
17 no evidence in the medical records that the baby was ever
18 infected.

19 Q. Okay. And did they look for that in the baby?

20 A. Yes.

21 Q. How did they look for it?

22 A. They did blood cultures on the baby.

23 Q. Blood cultures ever come back with anything?

24 A. No.

25 Q. Okay. At term and term or post-term mothers, what

1 percentage will have histological chorioamnionitis?

2 A. With long labors it can be, like, 50, 60 percent.

3 Q. Okay. We're going to hear from a pathologist from your
4 institution. What's her name?

5 A. Rebecca Baergen, who is an outstanding placental
6 pathologist. Let me go on the record and say that.

7 Q. Here is -- this is page 37 of Exhibit 2. This is a
8 pathology report that reports the histological
9 chorioamnionitis, correct?

10 A. Right. I'm sure she's right.

11 Q. And this is actually the report from the Medical Center
12 done by Dr. DiMaio?

13 A. Sure.

14 Q. He writes: There's no significant histopathologic
15 change. No significant change.

16 A. Right.

17 Q. And then he writes that there is some pigment-laden
18 macrophages consistent with meconium.

19 A. Right.

20 Q. And there's membranes with chorioamnionitis -- and that's
21 what we're talking about, correct?

22 A. Right.

23 Q. And there's also a placental disc, that's where the gas
24 exchange occurs?

25 A. Yes.

1 Q. -- that has no significant histopathologic change.

2 A. Right. So parts of the placenta got infected. And of
3 note here, they see meconium. Remember when she ruptured her
4 members, she had clear fluid. And then all of a sudden she
5 delivers and there's meconium. What does that tell you? That
6 tells you the baby was stressed in labor.

7 Q. Okay. If the baby had expelled a lot of meconium, would
8 have -- the nurses are supposed to check, right?

9 A. Yes.

10 Q. And they're supposed to be monitoring the fluid that's
11 coming out of the vaginal vault?

12 A. Yes.

13 Q. And if there's meconium, they're supposed to note that,
14 right?

15 A. Yes.

16 Q. But safe to say -- well, how many reports have you seen
17 just like this sent back from Dr. Baergen, and the patient
18 went home fine, baby's fine? How many times?

19 A. Dozens.

20 Q. But there's chorioamnionitis. Doesn't that mean the baby
21 must have been injured a couple days ago?

22 A. Absolutely not. One thing has nothing to do -- she's
23 saying the placenta got infected, okay? And if she says, I
24 believe it. She's a great placental pathologist. That has
25 nothing to do with clinical chorioamnionitis, either in the

1 mother or the baby.

2 Q. Now, is chorioamnionitis a risk factor that can cause
3 some degree of hypoxia to a baby?

4 A. Absolutely.

5 Q. How?

6 A. Well, first of all, if the placenta is infected, it can
7 affect the oxygen exchange to the baby.

8 If the mother's infected and she gets sick, she can have
9 a delivery problem, if she gets sick enough, of delivering
10 oxygen to the placenta. And if the baby gets
11 chorioamnionitis, if the baby actually gets infected, the baby
12 can have issues with oxygen exchange.

13 So all of those things are possible. In this particular
14 case, it was just the placenta that was infected.

15 Q. Doctor, what are your ultimate opinions about the nursing
16 staff here? What -- how did they violate the safety
17 principles? How did they violate the standard of care?

18 A. When they --

19 MR. WELCH: Wait. Objection, form of the question.
20 You used the term "safety principles" and that violates this
21 Court's order.

22 THE COURT: Sustained. The question will be
23 specifically directed to standards of care.

24 MR. PATRICK CULLAN: Fair enough, your Honor. I
25 withdraw the question.

1 BY MR. PATRICK CULLAN:

2 Q. Doctor, what are your opinions as to how these nurses
3 violated the standard of care in the management of this labor
4 and delivery?

5 A. They violated the standard of care when they started
6 Pitocin on this patient. This patient was ten hours stuck at
7 7 centimeters. In order to start Pitocin, you need to
8 evaluate the Ps we talked about.

9 If they didn't do it, they need to have a physician do
10 it. They need to know before starting Pitocin as an advocate
11 for the baby that before you start that medication, you have
12 to know that it's the powers, and not the CPD, that's causing
13 this baby to be stuck for ten hours.

14 When they started the Pitocin, as soon as they see the
15 tachysystole and the reassuring tracing, they've got to turn
16 off the Pitocin. And the failure to turn off the Pitocin was
17 a deviation from good and acceptable practice.

18 They then -- the patient went 13 to 14 hours. And she
19 finally changed 1 centimeter. The failure on the part of the
20 nursing staff not to diagnose arrest of the active phase of
21 labor was a deviation from good and acceptable practice. And
22 they should have advocated for this mom, for her to have a
23 cesarean section.

24 Restarting the Pitocin --

25 MR. WELCH: Your Honor, if I could interpose an

1 objection to that last statement by the witness, it's a
2 misstatement, it's incorrect under Nebraska law as I
3 previously raised with the Court. I'd move that that be
4 stricken. Nurses do not diagnose.

5 THE COURT: All right. I will advise the jury that I
6 will be instructing you later at the end of the trial on the
7 law, specifically the law in Nebraska.

8 And beyond that, defense counsel can cross-examine on
9 that question when the opportunity comes up.

10 You may proceed.

11 MR. WELCH: Just so the record is clear, your Honor,
12 I neglected to also ask that the testimony of the witness be
13 stricken and the jury be told to disregard that opinion.

14 THE COURT: All right. To the extent that
15 Dr. Gubernick may have offered any opinion regarding a
16 responsibility under the law, you may disregard that. I will
17 be instructing you about what the law requires.

18 But he is testifying as to his opinions regarding the
19 standard of care and whether or not the two nurses who were
20 working at Bellevue Medical Center may have breached a
21 standard of care.

22 Go ahead.

23 BY MR. PATRICK CULLAN:

24 Q. Okay. So if I've heard you so far correctly, the first
25 one was the failure to evaluate the fit of the pelvis and

1 baby?

2 A. Yes.

3 Q. The second one was the failure to put in the IUPC to
4 assess the strength of the contractions?

5 MR. WELCH: I'm going to interpose an objection to
6 that. That was not his opinion. If it is this witness's
7 opinion, it's a misstatement of Nebraska law. Nurses are not
8 permitted to diagnose to do that. And therefore, I would move
9 that the question be stricken.

10 THE COURT: Overruled. I will allow the witness to
11 answer.

12 A. Yes, of course. The force we talked about, evaluating
13 CPD and what are the powers. And I should have expanded on
14 that to say -- you've heard me say multiple times today that
15 the only way to do that objectively, the only way to do that
16 is to put in an internal pressure catheter.

17 And in some institutions, nurses put in internal pressure
18 catheters. In some institutions, they need to ask a physician
19 to do that or a nurse-midwife. So I'm not saying that they
20 physically need to put in the internal pressure catheter. But
21 before starting the Pitocin, they need to have the knowledge
22 and they need to be an advocate to say, "We are not starting
23 the Pitocin until an internal pressure catheter is placed."
24 And their failure to do that was a deviation from good and
25 acceptable practice.

1 BY MR. PATRICK CULLAN:

2 Q. Okay. And then the third -- turning on the Pitocin, in
3 and of itself?

4 A. Turning on the Pitocin, not turning it off in a timely
5 manner; restarting it when it shouldn't have been started; and
6 in the late stages of labor, not turning it -- certainly not
7 turning it off in the later stages of labor and advocating for
8 cesarean section for the patient.

9 Q. Okay. I want to take these one at a time.

10 Did the failure to evaluate for the fit -- was that a
11 proximate cause of any damage to Sage?

12 A. Yes.

13 MR. WELCH: Objection, no proper and sufficient
14 foundation.

15 THE COURT: Overruled. He may answer.

16 A. Yes.

17 BY MR. PATRICK CULLAN:

18 Q. And of her brain damage?

19 A. Yes.

20 MR. WELCH: Same objection. And I would ask that my
21 objection precede the answer, and move that the answer be
22 stricken, no proper and sufficient foundation for this witness
23 to make a causation opinion.

24 THE COURT: The objection is overruled.

25 I will ask the witness that when an objection is

1 interposed, please wait so I can rule on the objection.

2 THE WITNESS: Sorry.

3 THE COURT: That's fine.

4 Go ahead.

5 BY MR. PATRICK CULLAN:

6 Q. And so the turning on of the Pitocin, was that
7 a proximate -- the violation of the standard of care as you've
8 said, was that a proximate cause of the brain injury that Sage
9 suffered?

10 MR. WELCH: Same objection, your Honor, no proper and
11 sufficient foundation for this witness to opine.

12 THE COURT: Noted, overruled. He may answer.

13 A. Yes.

14 BY MR. PATRICK CULLAN:

15 Q. The failure to diagnose the excessive uterine activity
16 and shut the Pitocin off after it was started, was that a
17 proximate cause of this injury and damage to Sage?

18 MR. WELCH: Same objection, no proper and sufficient
19 foundation, qualifications of this witness to render a
20 causation opinion in this case.

21 THE COURT: Overruled. He may answer.

22 A. Yes.

23 MR. PATRICK CULLAN: Can we have a standing objection
24 with regard to -- I'm just going through -- I mean, just with
25 regard to the record.

1 THE COURT: As far as I'm concerned, you certainly
2 may. Sometimes lawyers are concerned about whether the other
3 courts would recognize a standing objection.

4 MR. PATRICK CULLAN: Sure.

5 THE COURT: So I won't require counsel not to
6 interpose the objections.

7 But go ahead, Mr. Cullan.

8 MR. PATRICK CULLAN: Understood.

9 BY MR. PATRICK CULLAN:

10 Q. And was the failure to recognize that the Category II was
11 not going to bring back -- would not revert back, based upon
12 the circumstances, and advocate for a cesarean section, was
13 that also a proximate cause for Sage's brain injury?

14 MR. WELCH: Objection, no proper and sufficient
15 foundation, and outside the scope of this witness's
16 qualifications to so opine on causation.

17 THE COURT: Overruled. He may answer.

18 A. Yes.

19 BY MR. PATRICK CULLAN:

20 Q. Okay. And do you have an opinion as to when Sage's
21 injury occurred?

22 A. I'd say to a reasonable degree of medical
23 certainty that --

24 MR. WELCH: No, wait. Well, I've got an objection.
25 He can answer whether he has an opinion.

1 THE COURT: First, just tell us yes or no if you have
2 an opinion.

3 A. Yes, I have an opinion.

4 BY MR. PATRICK CULLAN:

5 Q. And what is that opinion?

6 MR. WELCH: Objection, no proper and sufficient
7 foundation for this witness to opine as to causation and
8 timing, outside the scope of his practice and expertise.

9 THE COURT: Overruled. You may answer.

10 A. More likely than not, the irreversible injury occurred
11 somewhere approximately around midnight.

12 BY MR. PATRICK CULLAN:

13 Q. And that's because of the data that shows that a
14 Category I going to a Category III is evidence of the injury
15 occurring?

16 A. Yes, sir.

17 Q. Okay.

18 MR. PATRICK CULLAN: At this time, I have no further
19 questions. Thank you.

20 THE COURT: Cross-examination?

21 MR. WELCH: I would, your Honor. It will take me a
22 second to get set up.

23 THE COURT: All right.

24 MR. WELCH: May I inquire, your Honor?

25 THE COURT: You may.

CROSS-EXAMINATION

BY MR. WELCH:

Q. Doctor, good afternoon.

A. Good afternoon.

Q. Last time we talked was in your hometown, New York City, in December; is that correct?

A. You're correct.

Q. You're an expert witness here today on behalf of the plaintiff, true?

A. Yes.

Q. As I understand it from your deposition, today you're charging \$11,000; is that correct?

A. Yes, you're correct.

Q. And I take it you've already been paid.

A. Yes.

Q. All right. And you also charge travel here, as I understand it from your deposition, of \$3,000; is that correct?

A. Yes.

Q. Plus, of course, your expenses.

A. Excuse me?

Q. Plus, of course, your expenses.

A. I charge \$3,000. And I worked while I was traveling, yes.

Q. When I took your deposition, the cost for that was

1 \$5,500, correct?

2 A. Yes, a half a day. I think we went beyond a half a day,
3 but that's what I charged.

4 Q. And you initially charged a retainer in this case of
5 \$3,000, I think, to initially review some records; is that
6 correct?

7 A. You're correct.

8 Q. And you've actually charged more than \$3,000, I assume,
9 in getting ready for trial here today and also to prepare for
10 your deposition, true?

11 A. Yeah. Well, as I told you, I use my travel time to
12 prepare for the trial, yes.

13 Q. Sure. But when I took your deposition in New York, you
14 had to prepare for that deposition.

15 A. You're correct.

16 Q. And you would have billed for that also.

17 A. I would think so.

18 Q. Do you know how much you would have billed for that?

19 A. No, but it wouldn't surprise me if it was four or five
20 hours of prep.

21 Q. Okay. And you typically charge what per hour?

22 A. \$550 an hour.

23 Q. Okay. So without -- if we added that prep time in, at
24 least by my quick math, we're up to about, oh, over \$25,000
25 that you've charged for this case. Is that fair?

1 A. Yes.

2 Q. Now, you testified at your deposition that I took that
3 you have probably testified by deposition 75 to 100 times.
4 Does that sound about that?

5 A. In 25 years, yes, maybe two or three a year on average,
6 yes.

7 Q. You told me that you get about one to two new cases every
8 month, correct?

9 A. Yes, that's true.

10 Q. And you've been testifying for the last 20 years, about
11 80 to 90 percent for plaintiffs; is that correct?

12 A. Yes.

13 Q. All right. But I think you told me within the last four
14 or five years, it's been about 50/50 between plaintiffs and
15 defendants, correct?

16 A. Not testifying, receiving cases.

17 Q. Okay. All right.

18 Have you testified about 50/50 for plaintiffs versus
19 defendants?

20 A. No, I haven't.

21 Q. Okay.

22 A. About 70/30 in the last couple years.

23 Q. For plaintiffs?

24 A. Yes.

25 Q. So over the last 20 -- I think you said you've been doing

1 this since 1989 -- you've testified against doctors and
2 hospitals all over the United States, correct?

3 A. This is the most west I've ever come, so I don't know
4 about all over the United States. But I've been in several
5 states.

6 Q. Is this your first time in Nebraska?

7 A. Yes, sir.

8 Q. Do you know where Bellevue, Nebraska is even located?

9 A. I can't tell you where Bellevue is, no.

10 Q. So whether it's south of Omaha, or north of Omaha, or
11 west of Omaha, you -- I mean, you don't know.

12 A. You're correct.

13 Q. Okay. You've been sued yourself over five times for
14 medical malpractice.

15 A. I have, yes.

16 Q. Four of those cases you actually went to trial. And you
17 won those cases, didn't you?

18 A. I did.

19 Q. And in those cases we had a situation just like we have
20 here. We had a jury, correct?

21 A. A situation like here in that we had a jury, correct.

22 Q. And that was back in New York.

23 MR. PATRICK CULLAN: Objection, relevance.

24 A. Yes, sir.

25 THE COURT: Excuse me?

1 MR. PATRICK CULLAN: Objection, relevance.

2 THE COURT: The relevance?

3 MR. WELCH: He's an expert. His credibility is at
4 issue.

5 THE COURT: I'll let you follow up a little more.

6 MR. WELCH: Sure. I just have a couple more
7 questions.

8 BY MR. WELCH:

9 Q. When you were a defendant yourself, you had the
10 opportunity to bring in other experts in obstetrics or
11 gynecologists to testify you met the standard of care,
12 correct?

13 A. You're correct.

14 Q. And you took the witness stand yourself and defended
15 yourself, didn't you?

16 A. I did.

17 Q. All right. Yet the plaintiff in that situation had other
18 experts in your specialty who came in and testified that you
19 fell below the standard of care. Correct?

20 A. Yes.

21 Q. And you would agree with me that experts can be qualified
22 and disagree on the standard of care.

23 A. Yes.

24 Q. As they did in the four cases that you were sued.

25 A. Yes.

1 Q. Now, you're not a member of the American College of
2 Obstetrics and Gynecology.

3 A. No. I voluntarily resigned.

4 Q. Right. And ACOG -- that's the acronym, correct, ACOG?
5 Yes?

6 A. Yes.

7 Q. They publish, I think, that about 90 percent of
8 obstetricians or gynecologist are members. Does that surprise
9 you at all?

10 A. I don't know. If they say it, I have no reason to
11 believe they're not being truthful.

12 Q. Okay. I think you testified earlier you do about 75
13 deliveries per year, and that's been about for the last four
14 or five years.

15 A. About, yes.

16 Q. Okay. Let's talk about -- a little bit about what you're
17 not. You're not a expert on placenta pathology.

18 A. Not at all.

19 Q. Okay. And you -- right at the end of your direct exam,
20 you talked about Dr. Rebecca Baergen is at the same hospital
21 where you're at, correct?

22 A. Yes. I've known her for years.

23 Q. All right. And would it be fair to say that she is
24 recognized worldwide as a expert in her field?

25 A. I don't know worldwide, I consider her an outstanding

1 placental pathologist.

2 Q. And you would certainly defer to her in this case with
3 respect to opinions related to placental pathology.

4 A. If we're other talking about --

5 MR. PATRICK CULLAN: Form of the question -- object
6 to the form of the question.

7 THE COURT: Overruled.

8 A. If all we're talking about is what she sees under the
9 microscope, I have no issue. She's smarter than I am on that
10 issue.

11 BY MR. WELCH:

12 Q. I take it you would let her answer as to when the fetus
13 had an inflammatory response in her placenta because that's
14 her expertise.

15 A. It's not up to me to let her or not let her testify. She
16 can say whatever she wants to say.

17 Q. Okay. But you would defer to her as to when an
18 inflammatory response in the placenta occurred.

19 A. If we're talking about what she sees under the
20 microscope -- remember, all she got was the placenta. She
21 didn't get the mother; she didn't get the baby. Thank God.
22 All she got was the placenta. Whatever she says about the
23 placenta, I would defer.

24 Q. You're not a neonatologist, are you?

25 A. No.

1 Q. All right. So you don't treat critically ill children
2 with cerebral palsy, do you?

3 A. No.

4 Q. You are not an N-I-C-U doctor who takes care of these
5 children with cerebral palsy.

6 A. No, those are pediatricians.

7 Q. Okay. Would you defer to a neonatologist on the cause of
8 cerebral palsy and the timing of those injuries?

9 MR. PATRICK CULLAN: Objection --

10 A. Not in this case.

11 MR. PATRICK CULLAN: Objection, form of the question.

12 THE COURT: Overruled. The answer will remain.

13 MR. WELCH: I didn't hear your full answer so I'll
14 ask the court reporter to read it back to me.

15 (Answer repeated.)

16 BY MR. WELCH:

17 Q. So normally you would but not in this case?

18 A. No. What I'm saying is if we're going to be talking
19 about mechanisms of encephalopathy, I'm quite confident how
20 this child developed an encephalopathy.

21 Q. Have you read the neonatology opinions in this case?

22 A. No.

23 Q. Okay. So with respect to the defense experts and the
24 neonatology opinions, you don't know what they say.

25 A. No. What they say -- once the baby's born, that's their

1 job. My job is to evaluate labor.

2 Q. Sure. So I take it not knowing what the defense
3 neonatologists have to say in this case, you can't tell me
4 whether you agree or disagree with their opinions because you
5 don't know them. Is that fair?

6 A. I guess that's fair.

7 Q. You're not a pediatric neurologist, are you?

8 A. I'm not a pediatric anything.

9 Q. Whether it's a pediatric, a pediatrician or a neurologist
10 or a radiologist, that's not you.

11 A. Or a urologist or a cardiologist, that's not me. I'm
12 just a plain ole ObGyn.

13 Q. And pediatric neurologists, they treat children with
14 cerebral palsy, long term, do they not?

15 A. Yes.

16 Q. Okay. And would you defer to a pediatric neurologist on
17 the cause of Sage's injuries and the timing as to when it
18 occurred?

19 A. Not in this case, no.

20 Q. Okay. Have you read the opinions of the pediatric
21 neurologists, the defense experts in this case?

22 A. No.

23 Q. So you don't know what they'd have to say as to whether
24 you'd agree with them or disagree with them?

25 A. That's not my job. I'm not a pediatrician so I

1 wouldn't -- I wouldn't have an opinion on anything they said.
2 I'm looking at this purely from the point of view as an
3 obstetrician.

4 Q. Okay. And you are not a maternal-fetal medicine
5 specialist.

6 A. I am not.

7 Q. Okay. A maternal-fetal medicine specialist would have
8 more education and training than you do in obstetrics and
9 high-risk obstetrics, do they not?

10 A. They have more training. They don't have more training
11 in obstetrics than I do, they have more training in taking
12 care of sick women and sick babies during pregnancy than I do.

13 Q. All right. They also deliver children, do they not?

14 A. Some do, some don't.

15 Q. Okay. Do you, in your practice, refer patients to a
16 maternal-fetal medicine specialist?

17 A. I consult with them on a regular basis. I almost never
18 refer a patient out to them. I have one in my office, so...
19 I mean, so I have a world's expert in my office.

20 Q. Maternal-fetal medicine specialist, another name for them
21 is perinatologist.

22 A. Some call themselves a perinatologist.

23 Q. Have you read any of the reports of Dr. Andrew Robertson
24 in this case, a maternal-fetal medicine specialist?

25 A. No.

1 Q. Have you read reports of James Smith, Jr., another
2 maternal-fetal medicine specialist?

3 A. I only read what he had said when we had a conference.
4 So I know his opinions, yes.

5 Q. All right. Dr. Robertson, you've not read anything that
6 he had to say about this case.

7 A. No.

8 Q. And I take it not knowing what Dr. Robertson has to say,
9 you wouldn't be able to agree or disagree.

10 A. If he doesn't agree with me, I disagree with him.

11 Q. Okay. So if he doesn't agree with you, in your opinion
12 he's wrong.

13 A. Yes, sir.

14 Q. Now, I think your curriculum vitae is marked as an
15 exhibit in this case but I don't think it's been discussed
16 with you. A curriculum vitae is what?

17 A. It's an overview of your life as you see it.

18 Q. Okay. And as you see it in this case, it's one page,
19 correct?

20 A. Yes. I trained under the KISS principle. My first year
21 law student daughter has a ten-page CV and says I should
22 expand mine. I'm going to keep mine at one page.

23 Q. Fair enough. So your curriculum vitae is -- I've got it
24 right here -- one page.

25 A. Yes. I gave you the straight, simple facts.

1 Q. Right. It's got your education on it, where you did your
2 residency, where you went to college, where you went to med
3 school.

4 A. That's it.

5 Q. Okay. I notice on your CV that you don't have any
6 medical articles that you've ever written.

7 A. That's right. I've never -- I'm not a researcher. I
8 haven't written any articles. I'm a clinician.

9 Q. Okay. And you've never written any textbooks or chapters
10 in textbooks in obstetric or gynecology for that matter.

11 A. You are correct.

12 Q. Okay. And would it be fair to say that you've never done
13 really any medical writing in your professional work once you
14 got out of school?

15 A. I think that's fair.

16 MR. PATRICK CULLAN: That's asked and answered. I
17 think he asked and answered that already.

18 THE COURT: Overruled.

19 MR. WELCH: I'm sorry, was there an answer?

20 A. Yes. I said that's fair.

21 BY MR. WELCH:

22 Q. And you're not a reviewer for any obstetrical journals or
23 medical articles, fair?

24 A. That's also fair.

25 Q. Now, you brought up a ACOG criteria on direct examination

1 on neonatal encephalopathy, correct, in direct exam?

2 A. Specifically acute asphyxia, that subset of neonatal
3 encephalopathy, yes, I did.

4 Q. Okay. And this monograph that was done in 2003, that was
5 a product of evidence-based medicine; is that right?

6 A. Yes.

7 Q. All right. And evidence-based medicine, as I understand
8 it, Doctor, is basically that physicians -- and in this case,
9 we had not only the American Academy of Pediatrics, but also
10 the American Academy of Obstetrics and Gynecology reviewed
11 medical literature, studied this in depth, and came up with
12 certain criteria; is that correct?

13 A. Certain criteria for an acute asphyxia, yes.

14 Q. The way they did that evidence-based medicine is we have
15 Level I, Level II, and Level III type studies, correct?

16 A. You're correct.

17 Q. And are you familiar with what a Level I study is?

18 A. Yes.

19 Q. What is a Level I study?

20 A. Well, there's different criteria. I can't give you the
21 specifics, but it has to do with prospective randomized
22 studies.

23 Q. So they may take a group of, say, in this case, women who
24 deliver with certain categories if they are first-time
25 mothers, if they have certain findings on the fetal monitor

1 strips, and they study that and then they study the children,
2 just as a general rule.

3 A. As well as, like, they'll just look at multiple
4 institutions and just pull the records and do what's called a
5 meta-analysis.

6 MR. WELCH: I want to just show something to the
7 witness so we could just have it on for -- it's a
8 demonstrative exhibit.

9 THE COURT: All right. Ms. Frahm, will you please
10 shut down the monitors in the jury box.

11 MR. PATRICK CULLAN: May I have a copy?

12 MR. WELCH: I don't have a copy.

13 (Off-the-record discussion had.)

14 MR. PATRICK CULLAN: I guess -- okay. That's fine,
15 your Honor.

16 THE COURT: You may.

17 BY MR. WELCH:

18 Q. Doctor, this is the criteria to define an acute
19 intrapartum hypoxic event as sufficient to cause cerebral
20 palsy. Do you see that?

21 A. Yes.

22 MR. PATRICK CULLAN: May I object and have it zoomed
23 out so that all --

24 MR. WELCH: All right. We can --

25 MR. PATRICK CULLAN: He's kind of leaving out the

1 important --

2 MR. WELCH: All right.

3 BY MR. WELCH:

4 Q. See it all right?

5 A. Yeah. Now I can see it really well.

6 Q. Okay. And this was put together by the American College
7 of Obstetrics and Gynecology and also the American College of
8 Pediatrics, true?

9 A. Yes.

10 Q. All right. And the essential criteria -- and they must
11 meet all four; is that right?

12 A. If we're talking about acute intrapartum hypoxia, which
13 this case is not; but yes, we could talk about it if you'd
14 like to talk about it.

15 Q. Okay. And you would agree with me that under the facts
16 of this case, Sage does not meet the first criteria, which is
17 evidence of metabolic acidosis and fetal umbilical cord
18 arterial blood obtained at delivery below a pH of 7, true?

19 A. That's true. And I wouldn't expect her to meet the
20 criteria.

21 Q. Okay. And -- did you say you wouldn't have expected her
22 to meet the criteria?

23 A. No. This is not an acute intrapartum hypoxia. This is
24 -- when you get to number four, it's what it is, where it says
25 exclusion of other identifiable etiologies, such as trauma,

1 infectious conditions, genetics. This is what -- she has what
2 they say you need to exclude in order to define it as acute
3 intrapartum hypoxia.

4 So I agree with them. And I wouldn't anticipate that she
5 would meet the criteria because I don't believe she had an
6 acute intrapartum hypoxic event. She developed an
7 encephalopathy from an alternative pathway.

8 Q. Intrapartum is defined as how by the American College.

9 A. Intrapartum is during labor.

10 Q. Yes. This happened during labor, did it not?

11 A. Yes. But it wasn't an acute, it was a partial prolonged,
12 as I talked about.

13 Q. The American College defines that as a labor being the
14 active phase of labor, does it not?

15 A. Excuse me?

16 MR. PATRICK CULLAN: Objection, form. That's
17 nonsensical.

18 BY MR. WELCH:

19 Q. The acute intrapartum hypoxic, as the America College
20 defines it, is exactly the timing that we have here with Sage,
21 don't they? That's how they define it.

22 A. It's the timing, but it's not the mechanism.

23 Q. Sage also did not meet the fourth criteria, true?

24 A. Didn't meet the which criteria?

25 Q. The fourth criteria, that she had --

1 A. She has --

2 Q. -- you have to exclude --

3 THE COURT: Whoa, whoa. We have two people talking
4 again. Please finish the question.

5 BY MR. WELCH:

6 Q. You have to exclude other identifiable etiologies. And
7 I've highlighted infectious conditions since she had an
8 infectious condition in this case.

9 A. As you could have highlighted trauma also because she had
10 a traumatic condition as well. So I agree with your
11 underlining. It just wasn't complete.

12 Q. The pH cord gas, in this case, was normal, was it not?

13 A. It was a normal gas. And if it was a venous gas, it was
14 a normal gas for the mother. It was never documented whether
15 it was venous or arterial, arterial representing the baby, the
16 baby's oxygen status; venous reflecting the mom's oxygen
17 status. Whosever it was, it was normal. More likely than
18 not, it was the mother's.

19 Q. So whether it's the mother's or the baby's, so whether
20 it's arterial or venous, doesn't make any difference. In your
21 opinion, it's normal.

22 A. Yes.

23 Q. And it was 7.33.

24 A. Excuse me, when you say it doesn't make any difference, I
25 don't believe it was the baby's arterial gas. I believe it

1 was -- so it's not like it doesn't matter whether it's
2 arterial or venous. It's my opinion, based on the Apgar
3 scores, based on what that baby looked like at birth, that
4 this baby was acidotic at birth.

5 Q. But the objective medical evidence, Doctor, does not
6 support that, with a cord gas of 7.33, true?

7 A. If it was arterial, it wouldn't support it. There's no
8 objective evidence that it was arterial.

9 Q. So was Heather Ramsey ever asked what -- whether it was
10 arterial or venous?

11 A. She was asked in her deposition and she -- and of course,
12 why not say it was arterial. There was no documentation in
13 the medical records to say that it was arterial.

14 Q. So Heather Ramsey did say it was arterial.

15 A. She -- if I remember her deposition correct, she felt it
16 was arterial.

17 Q. She's the one that drew it, right?

18 A. Probably.

19 Q. All right. Wouldn't you think the person that's actually
20 drawing the sample would know whether it was arterial?

21 A. I would also think the person who drew it would document
22 what she did. So there are a couple of things that aren't
23 necessarily so.

24 Q. So you would agree with me that the objective cord gas in
25 this case does not support hypoxia-ischemia, intrapartum.

1 A. I don't agree with your statement. If we knew it was an
2 arterial gas -- and I wouldn't care, even if it was a normal
3 arterial gas, but we don't know it was arterial gas because
4 this criteria is not what happened in this case.

5 So I don't care about this criteria because this is not
6 an acute asphyxia. This is a partial prolonged asphyxia. And
7 you don't need to meet these requirements to be a partial
8 prolonged. You're picking -- you're talking about, you know,
9 a Chevy Volt when what happened here was a Chevy Impala.

10 Q. Doctor, isn't it true in this case that a cord pH of 7.33
11 is very inconsistent with the strip in your opinion?

12 A. If it's arterial, it's inconsistent. I believe more
13 likely than not it's not arterial.

14 Q. But that was your opinion back in December when I took
15 your deposition, wasn't it?

16 A. You asked me is it inconsistent if this is the baby's
17 gas, and I would say yes. I would have anticipated an
18 acidotic baby based on the descriptions the people in the room
19 gave, not that I saw. The people in the room said they were
20 surprised at how bad the baby looked when the baby was born,
21 that the baby had poor Apgar scores, was pale, did not respond
22 well.

23 That baby sounds acidotic to me. So I would not have
24 anticipated a normal gas. And I think more likely than not
25 the baby did not have a normal gas, the mother had a normal

1 gas.

2 Q. And I think you told me in December that this strip was
3 totally inconsistent with the injuries in this case with a
4 normal cord pH.

5 A. If the pH was reflective of the baby, I said I would be
6 surprised. Yes, I stick to that statement.

7 Q. All right. And that specifically the injuries in this
8 child, you testified previously are inconsistent with the
9 normal pH, true?

10 A. If it's -- how many times do I have to say it? If it's
11 the baby's pH. But we have no objective evidence that it's
12 the baby's pH.

13 Q. Even though we have the person that took the sample
14 that's testified that it was arterial, true?

15 A. The very person who is being accused of negligence, yes.

16 Q. Is Heather Ramsey in this courtroom?

17 A. I've never met Heather Ramsey. I wouldn't know.

18 Q. And I think you told me at your deposition that you can't
19 have this injury to Sage without metabolic acidosis, tissue
20 death. And this cord pH is not showing that injury, true?

21 A. I think you've asked me this question nine times and I've
22 answered. I would be surprised if this is the baby's pH.
23 It's my medical opinion to a reasonable degree of medical
24 certainty it's not the baby's pH.

25 Q. Doctor, I'm going to ask you one more time. Please

1 answer the question.

2 You can't have this injury without metabolic acidosis,
3 tissue death. And this cord pH is not showing this injury,
4 true?

5 A. I don't agree with that statement.

6 Q. I'm looking at page 167 from your deposition, Doctor.

7 A. Yes, sir.

8 Q. Line 2: Okay --

9 Question: Okay. Assume that we removed chorioamnionitis
10 from the picture, pulled the piece of the puzzle out, would
11 Sage Schmidt -- Schmidt -- am I pronouncing it correctly?

12 Me, Mr. Welch: Schmidt.

13 Question: -- Schmidt be neurologically normal?

14 Answer: I can't answer that.

15 Question: Assume we pulled out -- now, you were talking
16 about hypoxia, not necessarily metabolic acidemia or metabolic
17 acidosis, correct?

18 Answer: Well, hypoxia leads to an asphyxia and asphyxia
19 leads to metabolic acidosis.

20 A. I recall that. And I stick by that statement. That has
21 nothing to do with what you just asked me.

22 Q. Now, you talked quite a bit on direct examination about
23 whether we have decelerations, whether we have variability.
24 You talked about this strip in great detail with plaintiffs'
25 counsel.

1 The sole purpose for fetal monitoring is to determine the
2 acid-based status of the infant, is it not?

3 A. The sole purpose of fetal heart rate monitoring, is that
4 what you said?

5 A. Yes.

6 Q. Yes, the fetal monitoring.

7 A. I think ultimately that's true. I mean, it's sort of --
8 I don't love that statement, but I understand where -- whoever
9 authored -- you pulled that from, where they're coming from, I
10 think that's the ultimate goal.

11 Q. I pulled that out of the NICHD, which you've already
12 referred to.

13 A. Yeah. I understand. Even they don't like -- they're
14 good, but I don't have to agree with everything. I understand
15 where they're coming from, so I already agreed with it.

16 Q. And that's why you do it, right, at the end of the day?

17 A. Sort of the end -- at the end of the day, whatever we do,
18 all the things we do, we want to send home a healthy mother
19 and baby. That's what I told you.

20 Q. Okay. And I think this strip, as you testified to, was
21 Category II, which is indeterminate all the way up until about
22 midnight, right?

23 A. Yes. I think I said there may have been small elements
24 of time where if you just looked -- if you just flashed on
25 that time, it may not have been always a Category II. But I'd

1 say more importantly, the overall pattern was Category II,
2 yes.

3 Q. And so we don't have a Category III, at least your
4 opinion, until about midnight.

5 A. That's my opinion.

6 Q. And we know from the cord gas that the fetal acid-based
7 status of this infant was normal at the time of delivery.

8 A. I know you like that cord gas --

9 MR. PATRICK CULLAN: I'm going to object --

10 A. I know you like --

11 MR. PATRICK CULLAN: Objection.

12 THE COURT: Wait a minute.

13 MR. PATRICK CULLAN: I'm going to object as
14 argumentative at this point, your Honor. This point has been
15 beat to death.

16 THE COURT: Overruled. He may answer.

17 A. You know, do we want to have a discussion again about the
18 cord gas?

19 BY MR. WELCH:

20 Q. Can you...

21 A. The answer is no, I don't agree with you.

22 Q. Okay. But you did agree that the purpose for fetal heart
23 rate monitoring is to determine the fetal acid base.

24 A. At the end of the day, sure.

25 Q. Okay. You would agree with me that the literature

1 indicates that fetal heart rate monitoring has about a 98 to
2 99 percent false positive rate in predicting cerebral palsy,
3 correct?

4 A. I would agree with that statement.

5 Q. Okay. So your opinions in this case are based heavily on
6 your review of the fetal monitor strips, correct?

7 A. That's certainly a strong element.

8 Q. We spent a lot of time on it, didn't we?

9 A. Yes, sir.

10 Q. All right. And so you agree with me that the tool on
11 which you were basing your opinions in this case --

12 A. Yes.

13 Q. -- that my nurses fell below the standard of care and
14 that injuries caused to Sage Schmidt have a 99 percent false
15 positive rate in predicting injury to a fetus.

16 A. That's true. We jump into the pool way too often. We
17 probably save too many people who can get out of the pool
18 themselves because we're unwilling to hurt a baby in labor.
19 You're absolutely right. And that's why the cesarean section
20 rate has risen in this country. We take babies out that have
21 a bad tracing that end up doing just fine to catch that one
22 baby who wouldn't be fine. And I'll do that every day of the
23 week.

24 Q. So you agree with me that the basis for your opinions in
25 this case are based upon a tool that only 1 percent of the

1 time has been shown to be accurate.

2 A. And when that 1 percent is your baby, it's 100 percent.

3 Q. That's your opinion.

4 A. That's my opinion.

5 Q. Okay. And you understand in this case that there are
6 others who disagree with that opinion, true?

7 A. With what I just said? No, I don't know anybody who
8 disagrees with what I just said.

9 Q. Okay. Well, you wouldn't because you haven't read the
10 reports.

11 A. So bring somebody in to disagree that when it's your
12 baby, it's 100 percent when your baby gets injured. Bring
13 someone in that disagrees with that statement. Go at it.

14 Q. You would agree with me that even among obstetricians,
15 they can't agree on what a tracing shows or the significance
16 of the tracing.

17 A. See, now that's inaccurate. What you fail to talk about
18 -- you talk about the false positive rate, which is very high.
19 But what you didn't talk about is the false negative rate.
20 And what we can all agree on is what a healthy baby looks
21 like.

22 MR. WELCH: Your Honor, I've let the witness -- I
23 think I asked a proper question in a leading manner and now
24 the witness is going beyond that.

25 THE COURT: All right. Sustained.

1 BY MR. WELCH:

2 Q. You would agree with me that review of a fetal monitor
3 strip is not objective.

4 A. I would agree that there's a subjective component to it,
5 but it's not purely subjective.

6 Q. Okay. Children that are born to first-time mothers who
7 deliver vaginally, just about 100 percent of them have
8 molding, do they not?

9 A. I wouldn't say 100 percent, but I would agree with your
10 premise that it's a lot.

11 Q. Above 90?

12 A. I think so.

13 Q. All right. And molding, just for the jury, is the fetal
14 head has what they call sutures; is that right?

15 A. Yes.

16 Q. And basically those sutures allow the head to mold so
17 that it can go through the pelvis.

18 A. I would agree with you.

19 Q. Okay. And that's very -- and that's very common. And
20 sometimes that's referred to as trauma, correct?

21 A. Somebody may refer to that as trauma. I wouldn't, but
22 some people would. And I wouldn't have a problem with that.

23 Q. And caput -- I think you explained what that is -- that's
24 basically swelling of the soft tissues.

25 A. You're correct.

1 Q. That's the cone head.

2 A. You're right again.

3 Q. And again, with first-time mothers who deliver vaginally,
4 that happens in about 90 percent of the cases, isn't it?

5 A. Somewhere -- it's a lot. I don't know if it's 90, but
6 it's a lot. I'll agree with the premise that it's a frequent
7 occurrence.

8 Q. This child had no cephalohematoma, correct?

9 A. You're correct.

10 Q. And cephalohematoma is what?

11 A. It's a hematoma, which is a collection of blood,
12 underneath the skull.

13 Q. The child had no bruising, correct?

14 MR. PATRICK CULLAN: Objection to form.

15 THE COURT: Overruled.

16 A. I don't have a recollection that the child had no
17 bruising. But whether the child had bruising or didn't have
18 bruising wouldn't change my opinion whatsoever.

19 BY MR. WELCH:

20 Q. Okay. You reviewed the records of the NICU, did you not?

21 A. I did. I just don't remember. If you tell me that they
22 commented there is no bruising, I trust you. But I just don't
23 remember that statement.

24 Q. It states no bruises.

25 A. I believe you.

1 Q. And the two ultrasounds that were done on this child on
2 November 2nd, 2012, I think at about six hours of birth, were
3 read by the radiologist as normal, correct?

4 A. Yes.

5 Q. All right. And then the ultrasound that was done the
6 next day was also read as normal, correct?

7 A. Yes.

8 Q. An MRI that was done on Sage about five and a half days
9 or so after delivery showed no obvious herniations,
10 hemorrhage, or hydrocephalus, correct?

11 A. Right. But that has nothing to do with what we're
12 talking about.

13 Q. You would agree with me. Or do you remember?

14 A. I agree it has nothing to do with what we're talking
15 about.

16 Q. I don't think that was my question. My question was do
17 you remember?

18 A. I remember it, and it has nothing to do with what we're
19 talking about.

20 Q. Okay. And you would also admit that if we were only
21 talking about head trauma in Sage, we would not have any
22 neurologic injury in your opinion.

23 A. I think if that's the only thing that happened, if they
24 let her labor too long, which they did, and the tracing was
25 beautiful, and the baby wasn't hypoxic, I think this baby

1 would not have been damaged.

2 Q. Tachysystole. You talked a little bit about that on
3 direct exam. Are you aware that current literature that finds
4 that uterine tachysystole that sometimes can be occasionally
5 prolonged is almost always benign?

6 A. I'm sure somebody wrote that. Certainly the NICHD has
7 spent a lot of time and money warning obstetricians against
8 tachysystole. The American College warns against it. If
9 somebody somewhere -- did you find an article where somebody
10 somewhere looked at some tachysystole that didn't have a bad
11 consequence? I don't doubt that for a minute.

12 Q. Let's talk about chorioamnionitis briefly. You would
13 agree with me that it's well known in the literature that it
14 increases the risk of cerebral palsy in term infants and that
15 some studies show that it increases it about five times with
16 term infants.

17 A. Five times is a very small number. But yes, if you look
18 at a subpopulation of babies that develop cerebral palsy, the
19 mother had a higher incidence of chorioamnionitis than the
20 general population.

21 Q. Okay. Are you familiar with the work by the CDC at all
22 that indicates those studies show increase in the risk with
23 chorioamnionitis and cerebral palsy?

24 A. Yes. Chorioamnionitis is a risk factor for the reasons
25 we talked about.

1 Q. If I use the acronym FIRS, are you familiar with that at
2 all?

3 A. Yes.

4 Q. That stands for fetal inflammatory response.

5 A. Syndrome, yes.

6 Q. Have you ever done any writing on it yourself?

7 A. No.

8 Q. This would probably be within the gamut of the
9 neurologists or neonatologists; is that fair?

10 A. To talk about FIRS?

11 Q. Yes.

12 A. Pediatricians would talk about that, yes.

13 Q. The nurses in this case were under the direction of a
14 certified nurse-midwife for this labor, were they not?

15 A. You're correct.

16 Q. And you do not work with midwives currently, do you?

17 A. I do not.

18 Q. You have in the past, true?

19 A. I have.

20 Q. All right. And from your review of the records -- and it
21 was not one of your opinions in the standard of care against
22 the nurses, the nurses faithfully fulfilled the orders of the
23 nurse-midwife in this case, did they not?

24 A. They fulfilled the orders of the nurse-midwife. Yes,
25 they did.

1 Q. I mean, the nurse-midwife ordered certain things, such as
2 Pitocin, correct?

3 A. Yes.

4 Q. And the nurses complied with that order, correct?

5 A. They did.

6 Q. Did you find in your forensic review in this case that
7 the nurses failed to follow any order that the nurse-midwife
8 gave?

9 A. No, just the opposite. They stopped an order that was
10 dangerous in terms of a drug that was -- the patient was
11 allergic to.

12 Q. The nurses stopped it?

13 A. Well, the pharmacy actually picked it up, and the nurses
14 didn't deliver it.

15 Q. And it's not your opinion in this case that failure to
16 deliver an antibiotic in this case had any effect on Sage's
17 injuries, true?

18 A. I would have been critical if the baby was infected, that
19 the baby didn't get antibiotics in labor. But we know the
20 baby never got infected, so the antibiotics are a moot issue.

21 But had this baby been damaged by chorioamnionitis, I
22 would have been very critical that antibiotics weren't given
23 during labor so that when the baby was born, the baby didn't
24 already have antibiotics in its system. But we already know
25 the baby never got infected, so it's a moot issue.

1 Q. So your opinion in this case isn't that failure to give
2 antibiotics caused any damage, true?

3 A. No, because the baby never got infected.

4 Q. Accelerations as shown on the fetal monitor strip, I have
5 down in my notes that you indicated that's not an acidotic
6 fetus, correct?

7 A. As a general principle -- I mean, rules get broken. But
8 as a general rule, when you see accelerations, that's a
9 reassuring sign that the baby is not acidotic.

10 Q. It's not your opinion in this case, Doctor, that the
11 nurses at Bellevue Medical Center did not care or have
12 professionalism towards this mother and this baby, is it?

13 A. I'm sorry?

14 MR. WELCH: Could you read the question back?

15 (Question repeated.)

16 A. I have no opinion on their care. I'm sure they're nice
17 people. I don't think they did this maliciously, they just
18 did it below the standard of care.

19 BY MR. WELCH:

20 Q. And you read in their depositions, they have a tremendous
21 amount of experience as obstetrical nurses.

22 A. They're veteran nurses.

23 Q. And I take it when you treat your patients, you try to
24 treat them professionally, do you not?

25 A. I do.

1 Q. And you consider yourself to be a dedicated healthcare
2 professional, right?

3 A. I do.

4 Q. Okay. And you have no basis in fact to say that these
5 two women caring for this mother and baby were nothing other
6 than caring people and healthcare professionals.

7 A. I don't think "caring" comes into this case at all.

8 MR. PATRICK CULLAN: I'm going to object to
9 relevance. I think this is seeking to inject sympathy. It
10 has no relevance.

11 THE COURT: Sustained.

12 BY MR. WELCH:

13 Q. Doctor, in this case you testified, and I quote, I mean,
14 take this woman in an alley and just put her out of her misery
15 rather than what you are doing to her. End quote.

16 Did you testify to that?

17 A. What I testified to was in situations like this, I had a
18 chairman who said, "Why did you let this go on? Why were you
19 so cruel to this person?" As a matter of fact, he went one
20 step further to say, Are you having an affair with, you know,
21 is that what this -- with the spouse? He would say that to
22 the female residents.

23 And he would say that it's more humane to take them out
24 to a back alley -- I was quoting somebody else -- and beat
25 them with a baseball bat than do what they did. That's what I

1 said.

2 I was quoting somebody else. I didn't say that about
3 this person. It was in the context of my training as a
4 resident.

5 Q. But you were directing that comment against Certified
6 Nurse-Midwife Ramsey, Nurse Laabs, and Nurse McLandsborough.

7 A. The point I was trying to make is that they let this baby
8 sit for 13 hours; 13 hours in a single position while the
9 uterus was contracting away. And to me, it's not only a
10 breach of the standard of care, I think it's -- I think it's
11 cruel.

12 Q. So you don't think you owe these ladies an apology for
13 stating that.

14 A. No, sir. If you let them read my entire deposition, it
15 was in the context of what people said to me. It wasn't what
16 I said to them.

17 You took it out of context. And if you want to read the
18 entire page, everybody in this room will know that you took
19 that statement out of context.

20 Q. You said it, didn't you?

21 A. I said -- if you're really interested, why don't you read
22 the whole page so people in this room will know that I didn't
23 direct it at the nurses. It was something that was directed
24 at me during my residency as a general principle.

25 Q. Doctor, Certified Nurse-Midwife Ramsey never ordered an

1 IUPC in this case, did she?

2 A. No, she did not.

3 Q. So she -- and you don't know at Bellevue whether nurses
4 can place an IUPC, do you?

5 A. I don't know whether they can or can't. It's irrelevant
6 to this case. They don't have to. They can get somebody else
7 to do it. It's not a problem.

8 Q. So as I understand your opinions, the nurses should not
9 have followed Certified Nurse Ramsey's order to start Pitocin.

10 A. You're correct. We all need to be advocates for our
11 patients, yes.

12 Q. They should not have followed Certified Nurse-Midwife
13 Ramsey's order to let the patient labor down. True?

14 A. When you say not follow orders, they just wouldn't do --
15 I'm not suggesting they don't do it. I'm suggesting a
16 dialogue. You know, we're a team. And we all have a common
17 goal which is the well-being of our patient.

18 So I'm not suggesting that they shouldn't follow the
19 orders, they shouldn't do it. I think what they should do is,
20 you know, say, "Hey, Heather, what's going on here? This
21 woman's been stuck for a day, for 12 hours, 13 hours. You
22 think Pitocin is a good idea? Why don't you put in an
23 internal pressure catheter. Let's see what the contractions
24 look like before we give the Pitocin."

25 I'm not suggesting a mutiny here; I'm suggesting a

1 dialogue.

2 Q. Doctor, your -- it's your opinion that the nurses fell
3 below the standard of care because they followed the nurse-
4 midwife's order to restart the Pitocin, true?

5 A. Yes. The Pitocin, as we all saw, should have never
6 been --

7 MR. WELCH: Your Honor, I think I asked it in a
8 leading manner.

9 THE COURT: All right. I'll just ask that you answer
10 yes or no, if you can.

11 THE WITNESS: Yes, Judge.

12 MR. WELCH: May I take moment, your Honor?

13 (Off-the-record discussion had.)

14 MR. WELCH: Thank you for your time, Doctor. No more
15 questions.

16 THE COURT: Let's go ahead and take our break at this
17 juncture. Please reconvene in the jury room at five minutes
18 after 4.

19 We're in recess. Thank you.

20 (Jury out and recess taken at 3:53 p.m.)

21 (At 4:07 p.m. on July 28, 2015, with counsel for the
22 parties, plaintiff Doran Schmidt, and the defendant's
23 representative present, the following proceedings were had:)

24 MR. PATRICK CULLAN: Just for scheduling, he's got a
25 flight to catch. So when we're finished with him, is it okay

1 if that's the end of the day?

2 THE COURT: That's fine.

3 Very good. Please bring in the jury.

4 (Jury in at 4:09 p.m.)

5 THE COURT: Redirect?

6 MR. PATRICK CULLAN: Thank you.

7 REDIRECT EXAMINATION

8 BY MR. PATRICK CULLAN:

9 Q. Dr. Gubernick, I just want to follow up with some of the
10 discussion you had before the break with defense counsel.

11 First let's talk about can't the nurses just do what
12 they're told. Do you remember that line of questioning?

13 A. Right.

14 Q. What's your understanding of nurse -- are nurses in labor
15 and delivery -- do they -- are they educated?

16 A. You know, maybe 100 to 150 years ago, that was the right
17 answer, that nurses do what they're told.

18 But now, we're in a different place and time where the
19 people who work in the hospital, we're a team. And
20 everybody's part of the team, and we have a common cause.

21 And I can tell you, the nurses -- they actually rule --
22 they rule labor and delivery. But seriously, what we are, I
23 mean, I just can't keep reiterating this, we're advocates
24 because we all want the same thing. We want to do the best
25 job we can do to send people home healthy.

1 And there's never an excuse where, in your mind you're
2 thinking, well, this is not in the best interests of the
3 mother or baby, but the doctor told me to do it or the midwife
4 told me, so I'm going to do it, even though my training, my
5 experience, my years as a nurse tell me that this doesn't feel
6 right.

7 And like I said before, I'm not talking about a mutiny
8 here; I'm talking about dialogue, conversation. You don't
9 have to yell at anybody. You don't have to call anybody out
10 on it. You go to a nice quiet place and say, "Could you
11 please explain to me why we're doing this because I'm
12 confused. And I just want to make sure we're doing the right
13 thing."

14 That's the kind of dialogue that occurs in Nebraska, in
15 New York, in California, in Illinois, in Washington; you name
16 it. Because as patients, you know, as well as being a doctor,
17 I've been a patient a couple times this year. As a patient,
18 that's what we expect from our healthcare providers.

19 Q. Okay. A couple of questions on that. And some of them
20 may be quite obvious, but is that commonly referred to in the
21 literature as the collaborative practice model?

22 A. Yes.

23 Q. Okay. Is one of the components of that is that there's
24 no more -- nurses are to be respected, their opinions are to
25 be listened to, and they should feel free to engage in a

1 dialogue with any co-healthcare professional they're working
2 with?

3 A. Not only should they be respected, these people have 20
4 years of experience. And they've been doing thousands of
5 deliveries on labor and delivery. It would be foolish on the
6 part of myself, a nurse-midwife, not to listen to these
7 people. Especially in the wee hours of the morning, when
8 we're all tired, we've all had enough. We've had a patient in
9 labor for a day or two, in this case three. Everybody gets
10 tired. Everybody gets on edge. Everybody misses their
11 family.

12 So we're all human. And sometimes we just need a nudge
13 from somebody to say, "Hey, listen, this is --

14 And sometimes, too, we get emotional because the patient
15 wants a vaginal delivery and we want to give them -- what we
16 want to do is we want to make people happy, so we go out of
17 our way. And sometimes to a fault, we go out of our way to
18 try to make somebody happy.

19 And someone has to say, "Hey, listen, I know you want to
20 make somebody happy, but let's talk about safety here for a
21 minute."

22 So that's -- that's all of our jobs, not just the nurse's
23 job, the midwife or doctor, charge nurse on the floor, you
24 name it. That's what our jobs are.

25 Q. In that line of questioning, if the culture at the

1 Bellevue Medical Center is such that it is a "follow orders"
2 mentality and there's not a collaborative practice model as
3 was suggested, is that in line with the safety principles that
4 govern labor and delivery in 2012 as it was?

5 A. Absolute --

6 MR. WELCH: Judge, I'm going to object. The question
7 is argumentative, no proper and sufficient foundation. It's a
8 representative of the impart of the question --

9 THE COURT: Sustained.

10 BY MR. PATRICK CULLAN:

11 Q. Is a -- is it within the standard of care to just simply
12 say, "I was following orders"?

13 A. Absolutely not.

14 MR. WELCH: Your Honor, I guess I'm going to object
15 to the question, along the lines that I objected previously.
16 I believe it's a -- this gets into a legal conclusion as to
17 what the law in Nebraska is with respect to nursing personnel.
18 And move that the question, and if there was an answer, be
19 stricken.

20 THE COURT: Well, again, I will advise the jury on
21 the law and what the law requires in the state of Nebraska.
22 Dr. Gubernick is offering his opinion regarding standards of
23 care.

24 Overruled.

25 BY MR. PATRICK CULLAN:

1 Q. Just going in reverse order kind of, the next thing that
2 was discussed was accelerations. And if accelerations are
3 present, if you can find them somewhere on the strip, that
4 somehow in and of itself, regardless of the other
5 circumstances, should be reassuring. Is that accurate?

6 A. No.

7 MR. WELCH: Objection, leading and suggestive.

8 THE COURT: Overruled.

9 A. No. An acceleration in and of itself is a reassuring
10 sign. You see the heart rate go up. That's a reassuring
11 sign.

12 We don't just look at things in and of themselves; we
13 look at things in their totality. You've got to look at the
14 whole strip and you've got to look at where the strip was for
15 the last half hour and what's going on.

16 So if you have flat line and decelerations and then all
17 of a sudden, you've got one acceleration, that's not
18 reassuring. That usually doesn't happen. But -- so what I'm
19 saying is usually you see an acceleration with a Category I
20 tracing.

21 But if you have a Category II tracing, or even
22 hypothetically speaking, a Category III with an isolated
23 acceleration, you have to look at the totality of the
24 situation and not just hang your hat on one particular example
25 of something that might be reassuring when you have all kinds

1 of other evidence that things are not reassuring.

2 BY MR. PATRICK CULLAN:

3 Q. Okay. I just want to go back. And we talked about if
4 you're in a Category II, the goal of every healthcare
5 professional monitoring that labor is to get it back to a
6 what?

7 A. A Category I.

8 Q. Okay. And if it's not going back, can they look at the
9 strip and say, "I see an acceleration here, I see an
10 acceleration here," and rely on that to establish the safety
11 of the child?

12 A. Absolute --

13 MR. WELCH: Objection, no proper and sufficient
14 foundation; but more importantly, outside the scope of cross.

15 THE COURT: Well, I'm going to sustain the objection
16 based upon the wording of the question. The wording was not
17 based on a standard of care, you were asking whether they can
18 do something. So sustained regarding wording.

19 MR. PATRICK CULLAN: Okay.

20 BY MR. PATRICK CULLAN:

21 Q. Sticking with the topic of accelerations, if you're in a
22 Category II that's not reverting to a Category I, can you --
23 strike the "can" -- is it reasonable to go in there and hunt
24 for accelerations and use that to justify continued therapy,
25 continued inaction to change the circumstance?

1 MR. WELCH: Objection, form, and outside the scope of
2 cross.

3 THE COURT: Sustained.

4 BY MR. PATRICK CULLAN:

5 Q. Counsel talked about the CDC has recognized
6 chorioamnionitis as a risk factor for cerebral palsy. Do you
7 recall that line of questioning?

8 A. Yes.

9 Q. And I guess we've done this again. How many times has
10 Dr. Baergen, who's come in here and told you that there was
11 chorioamnionitis in the placenta of a baby you had just
12 delivered and it walked out normally?

13 A. Many, many, many --

14 MR. WELCH: Objection to -- outside the scope of
15 cross, and it's repetitive of direct examination, asked and
16 answered.

17 THE COURT: Well, I do believe it has been asked and
18 answered. Sustained.

19 MR. PATRICK CULLAN: Okay.

20 BY MR. PATRICK CULLAN:

21 Q. With respect to the risk, put it in -- that you discussed
22 with counsel, can you quantify what it means in actual real
23 life medical practice?

24 A. What we have to look at is the converse of what he said
25 because it is true that babies that have cerebral palsy, their

1 mothers have a higher incidence of chorioamnionitis than the
2 general population. There is a correlation.

3 But the converse of that, 90 plus percent, 95, 96 percent
4 of moms who have chorioamnionitis, their babies do just fine
5 because if it's just related to the placenta, the mother or
6 the baby is not affected. And even if either the mother or
7 the baby are affected, we give antibiotics in labor and the
8 antibiotics take care of the problem.

9 And the overwhelming majority of moms who are diagnosed
10 with clinical, not histologic but even clinical
11 chorioamnionitis, they do fine and their babies do fine.

12 Q. Okay. I know there was a -- you discussed tachysystole.
13 He mentioned there may be an article out there that suggests
14 it is almost always benign. When it's not benign, what is it?

15 A. It's dangerous.

16 Q. What does that mean, dangerous? How?

17 A. First, I don't know the article, so I have to -- but I'm
18 sure somebody's looked at tachysystole. I looked at a hundred
19 cases, and many of these -- it's not about -- these troubled
20 tracings are not about being able to predict that the baby is
21 going to be neurologically impaired.

22 They're about the fact that we can't assure that the
23 baby's not neurologically impaired. In other words, we talked
24 about false positives being 99 percent. What we didn't talk
25 about is the false negatives; in other words, a reassuring

1 tracing is very reassuring that the baby's not in trouble and
2 the baby is going to be fine.

3 So a good tracing has a very high predictability of a
4 healthy baby. A bad tracing, as you heard, does not have a
5 good predictability of a bad baby. And that's why cesarean
6 section rate is high in this country. Like I told you, we're
7 going to jump in the pool when we don't like the tracing, and
8 we're going to take that baby out, knowing that the majority
9 of the babies we're doing sections on for a nonreassuring
10 tracing are actually going to be fine.

11 I'm not -- no obstetrician is ashamed of that because
12 we're just -- any baby we send home damaged is too many. 1
13 percent is -- if it's 1 percent -- if we let bad tracings go
14 on and 99 percent do just fine and 1 percent is severely brain
15 damaged, that's too many. We say in our society, that's
16 unacceptable. Maybe in other societies it's acceptable; in
17 our society, that's unacceptable.

18 Q. The next topic that was discussed was the neuroimaging
19 that Sage underwent after she was born. Do you recall that
20 line of questioning?

21 A. Yes.

22 Q. And the first ultrasound was done -- I think he was
23 correct -- at five or six hours of life. That was normal,
24 right?

25 A. And predictable, because if you have a partial prolonged

1 injury that's going on for hours in labor, you're not going to
2 see those changes on ultrasound for a couple of days. You're
3 not going to see it the first day or two. It takes time for
4 tissue that's been damaged for a lack of oxygen to present
5 itself on an ultrasound or an MRI as bad tissue.

6 So the normal ultrasound just reaffirms what I'm saying,
7 that two or three days before she went into labor, if that --
8 excuse my expression, but if that brain was bad -- I don't
9 know what was used here in this courtroom, eaten away, bad --

10 Q. Eaten away.

11 A. -- we would have seen an abnormal ultrasound right after
12 birth because it would have had days for that hypoxic event to
13 develop.

14 But when it happens intrapartum, it takes several days.
15 It takes a couple of days. Neuroradiologists who are more
16 specialized than I am in the field of reading these things,
17 they're going to come in and they're going to tell you that it
18 takes time for these pictures to become abnormal.

19 So if this brain was already bad two, three, four days
20 before delivery, that ultrasound would have been abnormal.
21 And it's the very fact that the ultrasound was normal that is
22 evidence that this was an intrapartum event.

23 MR. WELCH: Judge, I'm going to move that the
24 witness's answer in response to counsel's question be stricken
25 due to the fact that it violates Rule 702. This witness does

1 not have sufficient qualifications or ability to opine as he
2 just did as to the significance of fetal ultrasounds, outside
3 the scope of his practice or expertise.

4 And furthermore he referred to other experts, which I
5 think is improper, hearsay, and move that the jury be told to
6 disregard his answer.

7 THE COURT: Overruled.

8 BY MR. PATRICK CULLAN:

9 Q. You know Dr. Baergen who is going to testify, correct?

10 A. Yes.

11 Q. And you're on the East Coast; Cornell, Columbia, those
12 are on the East Coast, correct?

13 A. Yes, sir.

14 Q. Are you familiar with the neuroradiologist from
15 Stanford --

16 A. Yes.

17 Q. -- Dr. Barnes?

18 A. I mean, I've never met him, certainly aware of him. He's
19 got a big reputation.

20 Q. Okay. The next thing that was mentioned -- I can't read
21 that -- oh, you discussed with counsel the fetal tracing,
22 fetal heart rate tracings. Do you remember that, about
23 whether it's good?

24 A. Yes.

25 Q. And I think the insinuation was that it's -- I can't read

1 what I wrote, but fetal heart rate tracing is not perfect,
2 right?

3 A. Certainly.

4 MR. WELCH: I'll interpose an objection. The
5 question is argumentative, use of the word "insinuation".

6 THE COURT: Overruled.

7 A. It's an imperfect system. Yes, I agree with you.

8 BY MR. PATRICK CULLAN:

9 Q. And I think counsel tried to state that it's just flawed;
10 it's inherently flawed.

11 Are you aware of any institution, hospital, labor and
12 delivery unit that does not employ a fetal heart rate tracing
13 or a tocometer?

14 A. No. What I said -- he took the argument that because
15 we're not good at identifying damaged babies --

16 MR. WELCH: Your Honor, I'm going to object. I think
17 it's been asked and he answered it. Now he's going on into a
18 narrative.

19 THE COURT: Sustained.

20 BY MR. PATRICK CULLAN:

21 Q. If someone suggests that it's just so imperfect, why does
22 every institution in this country use it?

23 A. We use it --

24 MR. WELCH: Objection, form, that this witness can
25 opine as to why every institution uses something.

1 THE COURT: He may offer his opinion. Overruled.

2 A. We use it because it's really good at identifying healthy
3 babies.

4 BY MR. PATRICK CULLAN:

5 Q. I mean, if it's so bad, do you have an understanding --
6 or what's your opinion as to why Bellevue Medical Center would
7 use technology that they then turn around and say is useless?

8 MR. WELCH: Objection, form, foundation,
9 argumentative.

10 THE COURT: Sustained.

11 BY MR. PATRICK CULLAN:

12 Q. Counsel brought up the ACOG Joint Compendium from 2003.
13 Do you recall that?

14 A. I did -- I do.

15 Q. And I just want to talk about -- and you discussed with
16 him timing and how you're sure the injury occurred when you're
17 saying it did. Do you recall that?

18 A. Yes.

19 Q. Is the suggestion made in that text -- and this is the --
20 are you familiar with the Neonatal Encephalopathy and
21 Neurological Outcome, 2nd Edition publication?

22 A. Yes.

23 Q. We discussed this. Are you familiar that on page 210,
24 they discuss what evidence there is to support the
25 identification of the timing of a neurological insult?

1 MR. WELCH: Objection, your Honor, no proper and
2 sufficient foundation, was not used on direct. And
3 furthermore it violates this Court's previous order. This was
4 not a document identified by plaintiffs' counsel that this
5 witness was relying on. In fact, the witness, in his
6 deposition, said he was not relying on any medical literature
7 with respect to his opinions.

8 THE COURT: Well, Mr. Cullan, did Dr. Gubernick
9 identify this document as one he relied on for his opinions?

10 MR. PATRICK CULLAN: I think this was -- I don't know
11 if you want to do this -- I think this was discussed at the
12 hearing. In his underlying deposition, I can't represent to
13 the Court that he did.

14 THE COURT: Sustained.

15 BY MR. PATRICK CULLAN:

16 Q. Then I would just ask is the statement contained therein
17 authoritative that identifies what evidence supports drawing
18 the conclusion that an injury occurs --

19 A. Is there --

20 MR. WELCH: Objection, your Honor. Now he's using a
21 document which is not previously disclosed. The Court has
22 already sustained the objection. Now he's asking whether it's
23 authoritative. The Court has already stricken --

24 THE COURT: Sustained.

25 MR. PATRICK CULLAN: To lay foundation for cross-

1 examination using this document at a later date.

2 THE COURT: Excuse me?

3 MR. PATRICK CULLAN: Just to identify the document as
4 authoritative for use with other witnesses for impeachment
5 purposes.

6 THE COURT: All right. The witness may respond as to
7 whether or not he considers the document to be a reliable
8 authority.

9 A. The document is reasonably reliable, yes.

10 BY MR. PATRICK CULLAN:

11 Q. Okay. And particularly in terms of what it identifies as
12 how -- what you should look at to identify when the injury
13 occurs?

14 A. Yes, sir.

15 Q. Would that also be true with respect to the 23rd Edition
16 of the Williams Textbook of Obstetrics?

17 A. Yes, it's reasonably reliable.

18 Q. Thank you. I'm not using this any further.

19 Let's talk quickly about the cord gases. How many cord
20 gases were taken in this case?

21 A. One.

22 Q. What is -- the standard of care is to take how many?

23 A. Two; one on the baby side, one on the mother's side.

24 Q. Under the circumstances that this cord gas was taken with
25 Sage in the condition she was, would a reasonably prudent

1 healthcare professional get one cord gas?

2 A. No.

3 MR. WELCH: Objection, form of the question as it
4 relates to the parties involved in this lawsuit. The witness
5 has already testified nurses don't take cord samples.

6 THE COURT: Well, I understand that the midwife took
7 the cord sample. And I think that her actions are relevant to
8 the issues in this case.

9 Overruled. He may answer.

10 A. The standard of care is to take one on the mother's side,
11 which is venous, and one on the arterial side, which is the
12 baby.

13 BY MR. PATRICK CULLAN:

14 Q. Okay. If someone's a novice -- I mean, you've taught
15 people how to do this?

16 A. Many times.

17 Q. If someone's inexperienced or in a hurry or not being
18 careful, what's easier to get?

19 A. It's much easier to get the vein than the artery. The
20 vein is much bigger than the arteries.

21 Q. Explain how.

22 A. So what courses through the umbilical cord are two
23 arteries and the vein. And the vein -- we all know veins
24 are -- the walls of the veins are thin. And the arteries are
25 little and tight.

1 And the difference in size is maybe three- to four-fold
2 in diameter. You see the big vein coming through, and on each
3 side, you have a little artery. So if you're going to hit one
4 of them, statistically you're much more likely to hit the vein
5 than one of those arteries.

6 Q. And I just want to explain -- you had a discussion with
7 counsel for a long time about what the significance of it is
8 if it's venous versus what the significance is if it's
9 arterial. Do you recall that conversation?

10 A. Yes.

11 Q. So if you take the easy route and you draw the blood from
12 the vein, whose status are you measuring?

13 A. The mother's side.

14 Q. Okay. So if you get a blood draw back and it's good,
15 what information does that tell you about the mother?

16 A. She's being well oxygenated.

17 Q. Okay. What information does this tell you about the
18 baby?

19 A. Very little.

20 Q. Okay. Conversely, if you take, as the standard of care
21 requires, two samples, one from the vein and one from the
22 artery, what information now do you have about the baby?

23 A. Obviously you can see the difference. These are pipes
24 going into the baby and out of the baby. And if the
25 placenta's severely affected, they'll both be affected. It's

1 wherever the real damage occurs.

2 But if you get -- if the mother is being well oxygenated
3 and the problem is in the placenta or past where the mother's
4 vessels are entering the placenta, then you get a nice pH on
5 the mother and the baby is in trouble because you'll get a bad
6 pH on the baby.

7 So one is on the baby's side and one is on the mother's
8 side. We like to see both to see where the trouble began. So
9 we're being, like, detectives. Is it the mother's lungs? Is
10 it the mother's heart? Is it at the level of the placenta?
11 Is it at the level of the cord?

12 And in this particular case, you have no reason to
13 believe the mother wasn't healthy and doing well. They were
14 giving her oxygen, she was on her side, she's being well
15 oxygenated.

16 So if this came from the vein, it's no big surprise. The
17 baby came out pale, poor Apgars, needed resuscitation. I
18 wouldn't anticipate a normal gas on that baby. I would have
19 anticipated that this baby would have had an abnormal gas.
20 And we're never going to know. It's up to you people to
21 decide which side that came from.

22 But I will tell you, it's inconsistent with a baby who
23 came out looking shocky like this baby did.

24 Q. Okay. I want to -- the next thing he talked about was
25 Level I, Level II, Level III evidence. Do you recall that?

1 A. Yes.

2 Q. Level I evidence is where you do prospective, going-
3 forward studies, correct?

4 A. Yes.

5 MR. WELCH: Your Honor, I mean, I know it's running
6 late, but it's leading and suggestive.

7 THE COURT: Overruled.

8 BY MR. PATRICK CULLAN:

9 Q. So to do a prospective study as to whether or not, taking
10 the situation like Doran went through where you have a baby
11 stuck for 13 hours and then running it through with Pitocin,
12 how would you do a Level -- explain to the jury how you would
13 do a Level I study in that regard.

14 A. You'd have to go to a Third World country where the laws
15 would allow you to do that. In this country, thank God, we
16 wouldn't let that happen.

17 Q. Okay. What's an institutional review board? How's that
18 involved?

19 A. They would --

20 MR. WELCH: Judge, outside the scope of cross. Now
21 we're going into IRBs?

22 MR. PATRICK CULLAN: He brought up Level I studies
23 that have to have an IRB approval prior to it even being
24 allowed. It needs to be ethically appropriate.

25 MR. WELCH: I didn't go into that. I just asked him

1 if he knew what a Level I study was. Now we're getting into
2 IRBs?

3 THE COURT: Sustained.

4 MR. PATRICK CULLAN: Okay.

5 BY MR. PATRICK CULLAN:

6 Q. Just one quick follow-up on the same topic. Do you know
7 of any institution in the United States, Europe, that would
8 allow such a Level I study to ever be conducted?

9 A. Never would this be allowed to be studied. I've never
10 seen anybody stuck this long.

11 MR. WELCH: Judge, I'm going to object, move that it
12 be stricken.

13 THE COURT: Sustained. The jury will disregard the
14 last volunteered comment.

15 BY MR. PATRICK CULLAN:

16 Q. I guess this goes -- based upon your review of the case,
17 counsel talked about timing, if a pediatrician came in or a
18 neonatal intensive doctor came in and said that no, this brain
19 was eaten away three days before she ever got to Bellevue or
20 such like that, as was represented in opening statement -- two
21 questions.

22 First, do you have -- is there any objective evidence to
23 support that?

24 MR. WELCH: Objection, form of the question, outside
25 the scope of cross, calling for an opinion of what others may

1 say which this witness knows nothing about. And it's
2 argumentative.

3 THE COURT: Sustained.

4 BY MR. PATRICK CULLAN:

5 Q. Well, counsel discussed with you your opinion as to
6 timing. Do you recall that?

7 A. Yes, he did.

8 Q. He said, well, if a neonatologist has a different
9 opinion, what would you say about that? And he asked you if
10 there was a pediatrician, things of this nature. Do you
11 recall that line of questioning?

12 A. I remember that.

13 Q. Is there any evidence that you're aware of, having gone
14 through the records, that this brain was eaten away three days
15 before she ever got to Bellevue?

16 MR. WELCH: Objection, form of the question, no
17 proper and sufficient foundation, misstatement of the question
18 that was asked to the witness on cross-examination, so
19 therefore --

20 THE COURT: Sustained. The witness has already
21 testified as to his opinion as to when the damage occurred.

22 MR. PATRICK CULLAN: Okay. Thank you.

23 BY MR. PATRICK CULLAN:

24 Q. Oh, there was talk about ACOG and how many members it
25 has. Do you recall that?

1 A. Yes.

2 Q. So I want to just talk a little bit about what ACOG is.

3 ACOG is a professional association, true?

4 A. It's a fraternity of obstetricians, yes.

5 Q. Do they go to Washington, DC and lobby for laws and
6 preferential legal treatment, special interest legislation for
7 obstetricians?

8 MR. WELCH: Judge, I'm going to object; one, outside
9 the scope of cross; two, it's argumentative. I don't know
10 what that has to do with this case, even if it's true.

11 THE COURT: Overruled. He may answer.

12 A. Yes, they do. It's one of the reasons I resigned, yes.

13 BY MR. PATRICK CULLAN:

14 Q. Okay. One last topic. I can read that now. Counsel put
15 up the essential criteria. Do you recall that?

16 A. For an acute asphyxia. Yes.

17 Q. Did Sage -- let's talk about the applicability of that
18 criteria. Did Sage have a placental abruption?

19 A. No.

20 Q. Did she have a uterine rupture?

21 A. No.

22 Q. Did she have anything that led to an acute asphyxia?

23 A. No.

24 Q. Okay. The number four criteria specifically excludes
25 trauma.

1 A. Yes.

2 Q. Are they talking about car accidents?

3 A. They're talking about all kinds of trauma. They're
4 talking about trauma that happens from being in labor too
5 long. They're talking about forceps, vacuums. And they
6 include car trauma -- any trauma to the head. You can
7 traumatize the head of the baby many different ways.

8 So they're talking about a direct, physical insult to the
9 head of the baby. That can happen in labor, that can happen
10 during the delivery, and that can happen antepartum with an
11 accident.

12 Q. Okay. But by the very express criteria, the fourth one
13 excludes that type of mechanism.

14 A. Yes. They exclude that as a form of acute asphyxia. And
15 I think I've said it enough times today that this was not an
16 acute asphyxia and that's why this child did not -- that's why
17 this case doesn't meet that criteria.

18 This was an alternative pathway to an ischemic
19 encephalopathy, not that pathway, not the throw the child in
20 the swimming pool with weights on them to the bottom of the
21 pool, like a placental abruption or uterine rupture or
22 something of that nature.

23 Q. Just one final question. Had the -- one series of
24 questions, I suppose.

25 Had an intrauterine pressure catheter been inserted prior

1 to the institution of Pitocin, what do you believe it would
2 have shown?

3 MR. WELCH: Objection, outside the scope of cross,
4 and it was asked and answered on direct examination. It's
5 cumulative.

6 THE COURT: Sustained.

7 MR. PATRICK CULLAN: No further questions. Thank
8 you.

9 THE COURT: Very good.

10 Thank you, Dr. Gubernick. You may stand down and you are
11 excused.

12 THE WITNESS: Thank you.

13 THE COURT: We will end the day at this time, so you
14 can go home a little bit early.

15 Please enjoy your evening with family and friends. Talk
16 about something other than the case. Keep an open mind until
17 all the evidence is in and you've heard the arguments of
18 counsel.

19 Please reconvene in the jury room before nine o'clock
20 tomorrow.

21 We'll plan to start promptly at 9:00.

22 (Jury out at 4:39 p.m.)

23 THE COURT: And for the lawyers' information, I do
24 have an 8:30 sentencing so you'll need to move materials back
25 to the back tables.

1 All right. Thank you.

2 Have a good evening.

3

4 (Adjourned at 4:41 p.m.)

5

6

7 I certify that the foregoing is a correct transcript from
8 the record of proceedings in the above-entitled matter.

8

9

10 /s Brenda L. Fauber
Brenda L. Fauber, RDR, CRR

February 16, 2016
Date

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